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UNIVERSITY OF ALBERTA

Degree for which thesis was presented — Grade pour lequel cette thèse fut présentée

Ph.D.

Year this degree conferred — Année d'obtention de ce grade 1983	Name of Supervisor — Nom du directeur de thèse DR. D.A. McKay

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Interorganizational Relationships in a Clinical Service Delivery System

by

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A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF DOCTOR OF PHILOSOPHY

DEPARTMENT OF EDUCATIONAL ADMINISTRATION

EDMONTON, ALBERTA
SPRING, 1983

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ABSTRACT

This case study has been designed to examine the nature of interorganizational relationships which developed between the Diagnostic Clinic and a number of schools in order to determine the effectiveness of a clinical service delivery system. The subproblems were based upon Van De Ven and Ferry's (1980) model on the formation and maintenance of interorganizational relationships. Interorganizational relations were studied through 'situational,' 'structural' and 'effectiveness' dimensions. Each of these dimensions was analyzed in relation to the data. All names and places in the research project have been changed to ensure anonymity of the respondents.

With regard to methodology, participant observation was used as a technique to observe clinical specialists as they delivered services from the Diagnostic Clinic to the schools. Four case studies of client referrals were conducted and the impact of clinical service delivery was determined through contact with the parents, teachers and principals concerned with each of the four cases. Additional information concerning the Diagnostic Clinic's service delivery system was obtained through taped interviews with ten field specialists, ten principals, ten teachers and ten school counselors. Content analysis and Van De Ven and Ferry's (1980) model were used to classify data.

The following inferences have been extrapolated from the data. (1) When environmental pressures such as overextended case loads exist, a change in the design of the service delivery system is required to facilitate effectiveness. (2) When school personnel or parents are unwilling to take responsibility for carrying out recommendations proposed by clinical specialists, the effectiveness of the service is negligible. (3) The "jargon" used in the medical-professional orientation used for delivering clinical services may adversely affect communication with parents and school personnel. (4) Emphasis on diagnosis does not allow resources to be used to maximize intervention. (5) Evaluation of outcomes related to the delivery of clinical services requires more emphasis as implementation of recommendations and follow-up were found to be areas of weakness.

Implications regarding Van De Ven and Ferry's (1980) model have been proposed. The 'situational' dimensions of 'resource dependence' and 'awareness' were significant dimensions leading to the establishment of interorganizational relationships. However, the 'willingness of personnel to respond' was affected by the limited amount of time available for case work. 'Consensus' was related to the structural dimension 'centralization.' Boundary spanners could become more involved in decision-making and related follow-up of activities.

The following implications emerged concerning the 'structural' dimensions of Van De Ven Ferry's (1980) model. (1) Communication must be viewed as a two-way process between organizations. (2) The 'intensity' of contacts is affected by the number of tasks which must be performed and the willingness of all concerned to initiate contact. (3) Although 'formalization' of the contract of agreement between organizations may be satisfactory, it is essential that individual liaison mechanisms be analyzed to evaluate effectiveness. (4) The 'complexity' of the interorganizational relationship is affected by the competencies of personnel involved in interorganizational communication. (5) Effectiveness may be related to the 'situational' as well as 'structural' dimensions of an interorganizational relationship.

Acknowledgments

I wish to express my gratitude to Dr. Donald A. MacKay for the privilege of working under his direction and for his guidance and support during the course of this work.

I also wish to express my appreciation to my committee members; Dr. Chester Bumbarger, Dr. Peter Moody, Dr. Len Stewin and Dr. Ken Ward who gave valuable suggestions from their own research perspectives.

I wish to dedicate this work to my loving parents who have engendered the drive and persistance required to complete the task.

My wonderful husband, Micheal, friends and colleagues have given me unfailing support. I am eternally grateful to these individuals.

The dedicated staff of the Diagnostic Clinic deserve special thanks. Without their trust, openness and encouragement, this project would not have been possible.

Acknowledgment must be given to "Bobby", "Billy" "Tom" and "Mike" and their parents as they have personified the reasons why people must work together.

Special acknowledgment is given to Mrs. Margaret Voice who provided expertise encouragment and invaluable time by transcribing the raw data for this project.

Financial support administered through the Edmonton Public School Board's sabattical fund is gratefully acknowledged.

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Chapter 1

INTRODUCTION

Contemporary schools must be in a position to resolve problems concerning the child's behavioral and academic performance. Support for children with complex social, emotional and learning difficulties has been provided by the Diagnostic Clinic, a human service organization funded by the Oak View Public School Board. The primary goal of the Diagnostic Clinic has been to maintain and improve the well being and functioning of elementary school children who have severe difficulties in the classroom. The purpose of the organization has been to assess the child's academic abilities, behavior and attitudes in order to support school personnel and parents.

The Diagnostic Clinic has reached a stage in its development where an analysis of the service delivery system appears necessary. In 1980, the ramifications of decentralized budgeting threatened the very existence of the service. One perspective concerning the coordination of services between the Diagnostic Clinic and schools may be described by the term "interorganizational relationships." Hasenfeld and English (1974:1) have defined the term as follows: "Interorganizational relations are the variety of interactions between two or more organizations designed to enhance organizational goals." The focus of this study has therefore been to analyze the nature of interaction between the Diagnostic Clinic and the schools.

Need for the Study

Schools often rely upon clinical service delivery systems to cope with the inevitable series of problems which arise concerning the child's behavior. Authier (1977) conceptualized the delivery of clinical services as a therapeutic approach in which the student's functioning is analyzed not in terms of abnormality diagnosis, but in relation to school performance, in-depth behavior analysis and establishment of recommendations based on educational diagnoses and psychological testing. Rhodes (1980:18) suggested that more specific information be provided to teachers relative to the performance of individual students to assist in planning individualized instruction for children with special needs.

There has been conflicting evidence regarding the effectiveness of clinical service delivery. Lack of adequate service has been criticized by Cummings (1979) who indicated that administrators do not always adequately utilize funding for children with mental health and learning problems. Blau (1979) found that diagnosis of children is often used only to identify problems rather than for the purpose of planning preventative programs. Swanson (1976) as well as Cantrell and Cantrell (1977) have questioned the worth of clinical service delivery and suggested that the teacher become responsible for identification, diagnosis and programming for children who have difficulties. A study of interorganizational relationships has not been found in the area of clinical service delivery. Further research is therefore warranted.

Significance of the Study

This study has been designed to assess the nature of interorganizational relations between schools and a clinic in order to determine the merit of the clinical service delivery system. Hasenfeld and English (1977:540) provide a rationale for a study of this nature:

> It is useful to study interorganizational relationships in order to understand the conditions that lead to the emergence of relationships between organizations, to become sensitive to consequences of these relationships on intraorganizational structures, processes and clientele, and to become aware of the forms of linkages which effectively join organizations to each other.

Both Hall (1977) and Andrews (1978) have indicated that the study of interorganizational linkages between organizations is in a formative stage.

During the past decade, increased attention has been directed to interorganization dependencies and resource exchange between human service organizations. Hall (1977) stressed the importance of linkage forms which join organizations. Mutema (1981) used a conceptual framework which suggested that forms of linkage between organizations is a useful analytic approach. Information related to interorganizational relations will allow administrators to plan organizational changes which may be needed to improve the overall effectiveness of coordination systems. From this perspective, the understanding of relationships which exist between the Diagnostic Clinic and schools can be anticipated to enhance knowledge in the area of clinical service delivery.

Purpose of the Study

The study was proposed to examine the nature of interorganizational relationships between the Diagnostic Clinic and the schools in order to describe the impact of clinical service delivery. This study was therefore designed to observe the process of clinical service delivery, describe the nature of interorganizational relationships which developed between the Diagnostic Clinic and schools and determine the effectiveness of the clinical service delivery system. The influence of the child's home environment was also considered as it is a major aspect of clinical assessment. The research data have been classified according to the categories related to Van De Ven and Ferry's (1980) model concerning the formation and maintenance of interorganizational relationships.

Using Van De Ven and Ferry's (1980:300-201) model, the situational variables which have been analyzed focus on (1) the school's need for clinical support, (2) capacity of the Clinic to handle referrals, (3) the school's knowledge of the Clinic's services, (4) the extent to which the schools and Clinic are in agreement with respect to recommendations and (5) the similarity of skills between school and Clinic staff. Structural variables such as (6) the nature of communication, (7) coordination of services, (8) type of client referrals or skills of personnel, as well as (9) decision making between the organizations have been examined. The (10) effectiveness of the interorganizational relationship has been determined by the school personnel's reaction to the Clinic's service delivery system.

Statement of the Problem

The central problem in this study has been to describe the interorganizational relationships which exist in the service delivery system between the Diagnostic Clinic and schools. The subproblems to be investigated in this study have emerged from Van De Ven and Ferry's (1980) model on the formation and maintenance of interorganizational relationships. An interorganizational relationship consists of 'situational,' 'structural' and 'effectiveness' dimensions. Data have been analyzed according to these dimensions but not to the exclusion of other categories which have emerged. Many problems arise outside of the school; therefore, influences from the home environment have also been considered through four case studies of client referrals.

The first five subproblems have focused on the following situational dimensions:

1. Resource Dependence. Do school personnel perceive a need for the service provided by the Diagnostic Clinic?

2. Response to Problems. What are the Clinic's problems and possible solutions related to the Clinic's capacity to handle referrals?

3. Awareness. Are school personnel knowledgeable concerning goals and services of the Diagnostic Clinic?

4. Consensus. To what extent do school personnel and the Clinic staff agree with recommendations regarding referrals?

5. Domain Similarity. Can school personnel provide the same level of clinical service as that available through the Diagnostic Clinic?

The structural dimensions of the interorganizational relationship have been studied through the following subproblems:

6. Intensity. What is the school personnel's reaction concerning communication with the Clinic?

7. Formalization. How are the referral procedure, case conference, final report and follow-up perceived by school personnel?

8. Complexity. What are the school's concerns regarding roles and responsibilities of Clinic and school personnel?

9. Centralization. To what extent are school personnel and Clinic staff involved in decision making?

The school personnel's satisfaction with the Clinic's service delivery system has been determined.

10. Effectiveness. Is the Diagnostic Clinic's service delivery system considered effective by school personnel?

Description of the Study

The proposed research has been an intensive case study conducted at the Diagnostic Clinic located in a public school in Oak View, New Durham. A school psychologist, speech pathologist, reading specialist, social worker and diagnostic teacher have been observed in the process of delivering clinical services. Four case studies of elementary school pupils were carried out in order to focus on the service delivery system and liaison between clinical staff, schools and parents. The impact of clinical service delivery was determined through interviews with the principal, teacher and parents of each of the four students. Additional perceptions concerning the nature of interorganizational relationships have been obtained through interviews with ten field specialists, ten principals, ten teachers and ten counselors.

The setting for the study was the Diagnostic Clinic, a psychoeducational assessment center funded by the Oak View Public School Board. The center was managed under the administration of Childhood Services in the Pupil Personnel Department. The personnel of Childhood Services were responsible for handling casework concerning pupils who are experiencing academic, social or emotional difficulties. Childhood Services consisted of twelve interdisciplinary field teams created to carry out consultation and program planning to assist schools in the system. When a member of one of these teams decides that a particularly complex case requires extensive assessment, a referral may be activated to the Diagnostic Clinic.

Assumptions

1. That the Diagnostic Clinic and schools can be viewed as autonomous organizations.

2. That the delivery of clinical services can be examined by analyzing the nature of interaction which develops between the Clinic and schools.

Limitations

1. Qualitative measures are sometimes viewed as biased.

2. Effects of the participant observer upon the behavior of respondents may constitute a limitation upon the findings.

3. The research on this study is based upon selected respondents, therefore, selection bias may affect the results.

Definition of Terms

Boundary Spanners

Boundary spanners are field specialists who obtain information about specific goals, services and resources existing in other organizations or agencies. The level of awareness of these individuals helps to identify the potential alternatives for obtaining resources for the organization (Van De Ven, 1976:312).

Clinical Service Delivery

Steps related to the delivery of Clinical Services are outlined:

1. School personnel refer the student to a field specialist who screens appropriate candidates for placement in the Diagnostic Clinic.

2. Field specialists arrange to have the student placed in the Diagnostic Clinic for a three week period to determine a diagnosis and initial suggestions for remediation of the problem.

3. Clinic specialists schedule follow-up case conferences to provide teachers, parents and school personnel with significant information and interpretation of test results.

4. Clinic specialists develop recommendations to integrate the child back into the regular classroom or to provide an alternate school placement.

Clinical Specialists

The clinical specialists are the psychologist, reading specialist, speech pathologist and diagnostic teacher who are the professionals employed at the Diagnostic Clinic. These individuals have been assigned to provide indepth psychoeducational assessments and to develop remedial plans and recommendations for pupils referred from schools.

Domain Similarity

Domain similarity is the degree to which field specialists and clinical specialists have the same goals, same professional skills and provide similar services to clients. Domain similarity may help or hinder the establishment of an interorganizational relationship (Van De Ven, 1976:309)

Field Specialists

Field specialists are psychologists, speech pathologists, reading specialists or social workers who work together on inter-disciplinary field teams. These individuals screen referrals between the schools and the Diagnostic Clinic.

Focal Organization

The Diagnostic Clinic is viewed as a focal organization or central agency which interacts with schools as organizations in the environment. The focal organization is therefore embedded in an environment of input and output organizations with which it has interactions (Hasenfeld and English, 1974:54).

Interorganizational Relationships

The coordination of services between the Diagnostic Clinic and schools is based upon the formation and maintenance of interorganizational relationships. Interorganizational relationships are established when two or more organizations bind themselves together by performing specialized activities to attain mutual objectives (Clark, 1965:234).

Organization of the Thesis

The content of this chapter has focused on (1) the purpose of the study, (2) need for the study, (3) statement of the problem, (4) a description of the study, (5) assumptions, (6) limitations and (7) definition of terms.

Chapter 2 reviews literature and research pertaining to systems theory, interorganizational relationships and clinical service delivery. In this chapter a conceptual framework is presented which is based on Van De Ven and Ferry's (1980) model on the formation and maintenance of interorganizational relationships.

Chapter 3 outlines the research design and methodology used in this study. The case study approach, participant observation and the interview as an observational technique are discussed. Specific techniques used for data collection and criteria related to the trustworthiness of qualitative data are described. Chapter 4 presents a description of the Diagnostic Clinic's background, operating procedures, personnel and organizational concerns.

Chapter 5 provides findings related to the study of the service delivery system between the Diagnostic Clinic and the schools. Interview results obtained from contact with the school personnel who worked with the students are described and the reactions to four case studies are discussed. In Chapter 6, findings obtained from interview data are discussed. Van De Ven and Ferry's (1980) model is analyzed in relation to the findings.

Chapter 7 presents the summary, conclusion, implications and suggestions for further research. Observations pertaining to interorganizational theory are analyzed in relation to the study.

Chapter 2

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

The review of the literature will focus on selected areas in order to study the nature of interorganizational relationships. The conceptual framework will be based upon organizational theory related to the open systems approach, loosely coupled systems and effects of the environment. In the second section, an overview of interorganizational relationships will be discussed. In the third section, issues related to clinical service delivery will be reviewed and related research concerning home and school liaison will also be presented.

Organizational Perspective

The study has been concerned with examining the relationships between the Diagnostic Clinic in interaction with schools. A discussion of each of the following areas will provide background for the study. (1) Interorganizational relationships will be conceptualized through open systems theory. (2) Since interorganizational relationships develop when there are various degrees of interdependence between organizations, it seems appropriate to consider these organizations as loosely coupled systems. (3) The selection of literature and the method of analyzing these organizations recognize the importance of field specialists who are the boundary spanners coordinating referrals between the Diagnostic Clinic and schools. (4) The effects of the schools and pupils' home backgrounds will be considered as influences of the environment.

Open Systems Theory

A system may be conceived as an entity in the form of a structure or operation, concept or function, composed of united and integrated parts. The term system can refer to a vast array of phenomena from the smallest "whole" to the total universe. There are two basic types of systems, "open" and "closed." Open systems are those which exchange resources with their environment. Closed systems are self-contained, and are unaffected by other systems or their environment. Briefly defined, Bertalanffy

(1972:417) states:

> An open system is a set of elements standing in interrelation among themselves and with the environment. Open systems interact with and use their environment to combat entropy or inertia and exist in a dynamic state typified by increasing order, differentiation, variation and complexity.

Immegart and Pilecki (1973) and Katz and Kahn (1966) have outlined the universal properties of systems. All systems regardless of their nature, size or type tend toward entropy, a state of randomness, disorder, inertia or ultimate death. All systems exist in a time-space dimension and have boundaries which are more or less arbitrary. There is relevance in the fact that it is easier to move within a boundary than across it. A system's environment is everything which is outside of the system's boundary. All systems also have internal factors called variables and external factors called parameters. Finally, all systems have subsystems which themselves have yet smaller subsystems.

The open systems approach has been conceptualized by Steers (1977) as being composed of three basic components: (1) input, (2) throughput and (3) output. The utility of the systems approach in determining effectiveness is outlined by Steers (1977:6):

> An important concern in any examination of organizational effectiveness is specifying the nature of the relationship among major sets of variables as they jointly affect desired outcomes.

In order to determine effectiveness using the open systems model, the problems of interdependence and relationships between variables must be considered. The role of management, organizational characteristics, environmental and employee characteristics as well as policies and practices contribute to the success of the organization.

Because inputs are processed to yield outputs, organizational behavior consists of a series of goal-directed events. There are cause and effect relations among the events. Each event has its own cyclical pattern of subgoal-directed activities and choices and is therefore a subsystem. The subsystems are exhibited as vertically and horizontally differentiated components (disciplines) and positions (jobs). Van De Ven and Ferry (1980:7) proposed that the development and maintenance of relations within and between organizational components are exhibited in the flows of information and resources among positions and between organizations. The organization consists of many differentiated but interdependent subsystems which may be linked with other organizational systems through information and resource flow.

Loosely Coupled Systems

Interorganizational relations may be described through the concept of loosely coupled systems where the word coupling has been viewed as synonymous with connections, links or interdependence. Glassman (1973) categorized the degree of coupling between two systems on the basis of activity which the two systems share. Weick (1976) conveyed the idea that coupled events are responsive but each event also preserves its own identity. A loose coupling between either organizations or events may carry the connotation of impermanence, dissolvability and tacitness. There are various elements which may be coupled within the structural dynamics of organizations. Shared goals and consensus may be identified as loose couplings between systems.

Scott (1982:117) has attempted to spell out the implications of loosely coupled systems at the ecological level. Rather than focusing on organizations, the focus of the ecological approach is on "organizing." Weick (1969:91) defines organizing as the resolving of equivocality in an enacted environment by means of "interlocked behaviors embedded in conditionally related processes." Weick (1974:358) states:

> The word, organization, is a noun and it is also a myth. If one looks for an organization one will not find it. What will be found is that there are events, linked together, that transpire within concrete walls, and these sequences, their pathways, their timing are the forms we erroneously make into substances when we talk about an organization.

From this perspective, the activities of organizing are directed toward the establishment of a workable level of certainty.

Glassman (1973) identified the following potential functions of loosely coupled systems. Loose couplings lower the probability that organizations will have to respond to each change which occurs in the environment. Loosely coupled systems also have the potential for localized adaptation where the antithesis of localized adaptation is standardization. When uniqueness, identity and separateness of elements are preserved, a system may retain a greater number of novel components. Breakdowns may be sealed off without affecting other portions of organizational functioning. As well, the self-determination of personnel may be realized in loosely coupled systems. Weick

(1976:8) states:

> Reduction in the necessity for coordination results in fewer conflicts, fewer inconsistencies among activities, fewer discrepancies between categories and activity. Thus, loosely coupled systems seem to hold the costs of coordination to a minimum. Despite this being an inexpensive system, loose coupling is also a nonrational system of fund allocation and therefore, unmodifiable, and incapable of being used as a means of change.

March and Olsen (1975) utilized the elements of 'intention and action' in their conception of loosely coupled systems. In their argument, intentions are a poor guide for action, as intentions often follow rather than precede action. Intentions and actions are examples of elements which are loose couplings between organizations. Unfortunately, people in organizations spend a great deal of their time planning; however, intentions or recommendations are conceived as poor indicators of the way in which plans are carried out. 'Means and ends' are similar elements which have been identified as loose couplings. Frequently, several different means may lead to the same outcome; therefore, there may be alternate pathways for a coupling between 'means and ends.'

Boundary Spanners

The concept of loosely coupled systems implies that linkage is required between organizations. Coordination may be provided through individuals who perform what has come to be known as boundary spanning functions. Boundary spanners are individuals who obtain information about specific goals, services and resources existing in other organizations or agencies. Ratsoy (1980:4) described boundary spanners as individuals who play an important role in disseminating information about the organization. The more complex the organization, the greater the number of individuals involved in boundary spanning activities. Tushman (1977) found that boundary spanning roles evolved to link the organization's internal network to external sources of information in the environment.

Mindlin and Aldrich (1975:390) discussed the structures of organizational units that relate to boundary spanning functions. Boundary spanners are the most appropriate informants concerning an agency's interorganizational relations. Van De Ven (1976:308) indicated that the greater the length of time and degree of intimacy in the personal relationships between organizational boundary spanners the more similar their attitudes, values and goals. As a result of mutual trust, there is a greater predisposition to help one another by committing organizations to an interorganizational relationship. Stanek (1979) proposed that company trainers act as boundary spanners who consider influences of the larger community and various regulatory agencies. Boundary spanners often obtain information through informal channels and social networks.

Effects of Environment

The impact of environmental factors on loosely coupled systems has been documented in the writings of Aiken and Hage (1968), Evan (1965) and Litwak and Hylton (1962). Recently Hasenfeld and English (1974) discussed the issue of increased organizational interdependence which has been observed in human service organizations as they become more complex and diversified. Essentially, organizations engage in reciprocal interactions with other organizations in their environment in an effort to maintain dynamic equilibrium. Schein (1972:104-105) states:

> With the rapid growth of technology, the expansion of economic markets and rapid social and political change came constant pressures for organizations to change, adapt and grow to meet the challenges of the environment.

The effects of environmental factors have also been described by Hall (1977). Legal and political conditions may bring about new laws and policies which affect the organization. Economic conditions such as limited resources and an increased demand for service cause organizational constraints. Demographic, social and cultural conditions may also have an impact on the functioning of the organization. Organizations dependent on their environment adapt internal strategies to deal with perceived pressures. Baldridge and Burnham (1975) reported that environmental input from the community and other organizations is a major determinant of innovative behavior.

A relevant definition for the environment of an organization has been suggested by Hall (1977:312). An environment is "anything outside the organization which has an impact on it." There are, according to Kast and Rosenzweig (1970:133) two ways to conceptualize the environment: (1) the societal or general environment which is more or less the same for all organizations, and (2) the task or specific environment which affects individual organizations directly. Steers (1977) proposed that the external environment generally represents those forces outside of the organization itself and the internal environment represents those factors inside the organization which create the cultural and social milieu where goal-directed activities take place.

The literature which has been reviewed is related to Freeman's (1973:750) finding that "strong environmental pressures tend to increase formalization and general tightening of the organization." Kast and Rosenzweig (1970) pointed out that the environment of an organization may be based on the perceptions of managers. Information from the outside which is passed on through perceptive and cognitive processes may result in decisions affecting internal characteristics of the organization. In summary, there is strong empirical support for the notion which Magnusen (1973) has labelled the environmental imperative. This notion suggests that effects of the environment determine the structure most suited for a particular organization.

Interorganizational Relationships: An Overview

Of value in specifying environmental effects is increased understanding of interorganizational relationships. Van De Ven (1976:25) defined an interorganizational relationship as a social action system on the premise that it exhibits the following basic elements of any organized form of collective behavior:

1. Behavior among members is aimed at attaining collective and self interest goals.

2. Interdependent processes emerge through division of tasks and functions among members.

3. An interorganizational relationship can act as a unit and has a unique identity separate from its members. Interorganizational relationships may be studied when there are resource transactions, client referrals or staff services between organizations.

In the following section the work of major theorists such as Levine and White (1961), Litwak and Hilton (1962), Evan (1965), Marrett (1971), Van de Ven and Ferry (1980) and Whetten (1981) will be discussed.

Interorganizational Relationships

The purpose of formulating interorganizational relationships is to attain goals that are unachievable by the organizations independently. Litwak and Hylton (1962) and Levine and White (1961) suggested that human service organizations join together to establish a clearing house for client referrals and to promote areas of common interest. Organizations may jointly obtain and allocate a greater amount of resources than would be possible independently. The social structure between organizations in a social action system can act as a unit. This implies that the activities in interorganizational relations cannot be explained by analyzing individual member organizations.

Van De Ven and Ferry (1980) utilized concepts outlined by both Hall (1977) and Marrett (1971) in a model of the formation and maintenance of interorganizational relationships. The model postulates the existence of 'situational' factors both internal and external to a given organization which will explain the reasons why organizations enter into interorganizational relationships. Once an interorganizational relationship is established, it will take on a specific organizational form. This form is also determined by the 'structural' dimensions of the relationship. 'Structures' are the administrative arrangements established to define the role relationships among members. Structural dimensions include direction and frequency of resources and information flowing between systems. Outcome dimensions are related to perceived effectiveness of the relationship.

Situational Dimensions. All organizations depend on their environments for resources or clients to attain their objectives. Organizations may be pushed into interdependencies because of their need for resources such as specialized skills. The following 'situational' dimensions have been identified by Van De Ven (1980:308). (1) Resource dependence has been defined as the extent to which an organization needs external resources to attain its self-interest goals for a specified time. (2) Organizations must demonstrate responsiveness to external problems. (3) There must also be awareness of resources in other agencies where assistance or materials can be obtained. (4) Consensus has been defined as the degree of agreement or disagreement between members of the interorganizational relationship. (5) Domain similarity was defined as the extent to which organizations have the same skills and provide the same kind of service to clients.

Structural Dimensions. Van De Ven and Ferry (1980) also discussed the following structural dimensions . (6) The term intensity described the number of contacts or communication flows which may be transacted between organizations. (7) Formalization refers to the role behavior and activities regarding the interorganizational relationship. (8) Centralization refers to decisions which are binding between members of the interorganizational relationship. (9) The number of organizations in the interorganizational relationship and the different tasks or groups determine the complexity of the relationship. Without ongoing transactions such as resource and information flows, organizations will terminate their organizational relations.

Effectiveness. The (10) effectiveness of an interorganizational relationship refers to the extent to which agencies subjectively believe that each party carries out its commitments and that the relationship is worthwhile. Van de Ven (1976:311) postulates:

> The greater the perceived effectiveness of network organizations, the greater the dependence, awareness and consensus among the agencies. An interorganizational relationship may also dissolve when the organizations have achieved their self-interest objectives and no longer depend upon other agency members for resources or the attainment of a joint goal.

Apparently, not all the variation in commitment or dependence is explained by the perceived effectiveness of an interorganizational relationship, but there is a tendency to adopt new goals and solve problems when previous problems have been resolved.

Schein (1972) discussed the increasing importance of human resource planning and development for organizational effectiveness. A systems-level conceptualization of organizational effectiveness must be a multiple criterion involving adaptability, sense of identity, capacity to test reality and internal integration. Effectiveness has been conceptualized in terms of systems level criteria, acknowledging that every system has multiple functions within an environment that provides unpredictable inputs. A system's effectiveness is defined by Schein (1972:118) as "its capacity to survive, adapt, and maintain itself and grow regardless of the function it fulfills."

Analysis of Interorganizational Relationships

One approach to the analysis of interorganizational relations has been Evan's (1965) description of the interactions between a 'focal organization' and a network of organization' and a network of organizations in its environment. This involves the study of an 'organizational set' and outside interactions with a 'focal organization.'

Levine and White (1961) proposed another approach to the study of interorganizational relations. Organizational interdependence has been viewed as contingent upon the accessibility of each organization to necessary external sources, the objectives of the organization and the degree to which domain consensus exists between organizations. Based on these conditions, the directions and intensity of organizational exchange may be classified as being unilateral, reciprocal or joint.

In another approach, Marrett (1971) examined interorganizational relationships and concluded that there were four basic dimensions which could be identified.

1.Degree of Formalization. Formalization is the extent to which the relationship between the organizations is made explicit. There are two measures of formalization; the extent to which the exchange is given official sanction and the extent to which an intermediary coordinates the relations.

2.Degree of Intensity. Intensity is the kind and amount of involvement between interacting organizations. Intensity may be examined on a continuum with informal involvement at one extreme, and critical involvement at the other.

3.Degree of Reciprocity. Reciprocity is the extent of influence with respect to specific activities of each organization involved in the interorganizational relationship. Marrett (1971:93) proposes three approaches to reciprocity:

a. The first views a reciprocal relation as one in which there is a mutual flow of elements where a given behavior prompts a return.

b. The second deals with the extent to which the conditions of exchange are mutually agreed upon.

c. A third focuses on the balance of power of the interacting organizations.

4.Degree of Standardization relates to units of exchange or rules and procedures which are clearly delineated in the interorganizational relationship.

Hall (1977) suggested three aspects which must be considered when analyzing the nature of interorganizational relationships. (1) Criteria which may be analyzed are the frequency of interaction between organizations, (2) the degree of formalization of the interorganizational relationship and (3) the extent to which the relationship between organizations is cooperative or conflictual. Hall (1977:330) states:

> High degrees of formalization and centralization are related to lower levels of interorganizational interaction; and complexity, as indicated by the number of specialized personnel, is related to higher levels of interaction.

The basis of interorganizational relationships may differ according to whether or not the relationship is mandated by law or regulation, by some form of agreement or by involuntary means (Hall et al., 1977).

In a comprehensive review of the principal approaches developed by researchers in the study of interorganizational relationships, Marrett (1971:84-89) identified five approaches through which interorganizational relationships may be analyzed. The first approach described the properties of an organization affected by interaction with other organizations. The second approach compared certain attributes such as goal similarity in order to determine the relative compatibility between organizations. The relational approach focused on linkages between the organizations. The approach related to formal contextual properties outlined the influences of the larger organizational setting. Non-organized contextual properties suggested that social processes and conditions affect interorganizational relationships. Emphasis was placed on the unorganized environment and the degree to which it is subject to change.

Although Marrett (1971:88) identified five dimensions for the study of interorganizational relations, these dimensions are not mutually exclusive or in conflict:

> In fact, they should be viewed as complementary approaches to the study of interorganizational relations. Barriers to, or facilitators of cooperation, may be derived from the structural characteristics of an organization, from differences between organizations, from the nature of the relationship, from existing organizational activities or from social processes. A total analysis of interorganizational relations may be understood through understanding of the interplay between variables operating on all levels.

In order to obtain global insights regarding effectiveness, the five dimensions concerning the properties of interorganizational relationships must be considered.

Whetten (1977:77-81) proposed a model for designing interorganizational coordination systems. The model attempted to provide guidelines for determining the level of integration in a context. A matrix showing the relationship between three contextual dimensions and potential interorganizational problems was developed. The contextual dimensions included: (1) compatibility of organizations, (2) control over resources and (3) locus of initiative. Whetten suggested that increased efficiency may result from standardization. Standardized formalized interactions may be less likely to create frictions which undermine organizational relations.

Whetten (1981:288) outlined the antecedents of coordination. There are basically five conditions which must be met for voluntary coordination to occur. However, if coordination is mandated by law only three conditions must be met. (1) In the case of voluntary coordination, it is necessary for administrators to have a positive attitude toward the interorganizational relationship. (2) The need for the relationship must be sufficient to justify the cost of coordination. (3) There must be awareness of potential coordination partners. (4) Organizations must be aware of their complementary needs and there must also be an assessment of compatibility of the organizations. (5) There must be a capacity for the organizations to maintain the coordination. In mandated coordination, conditions (1), (3) and (5) cited above are required for successful coordination.

Major consequences of coordination have also been reviewed by Whetten (1981:299). When a dyadic linkage between organizations is placed in the larger context of a network, a natural consequence is increased interconnectedness. Tighter systematic integration reduces adaptive potential between organizations and may also reduce program innovation. It has also been argued that the negative side effects of extensive coordination between members of an interorganizational relationship may reinforce the status quo by hindering the entrance of new organizations, technologies or ideologies.

Related Research

Mutema (1981) studied the effects of interorganizational linkages between a Medical Training Center and eight departments of occupational therapy and physiotherapy in Kenya. The conceptual framework encompassed linkage dimensions and variables related to the effectiveness of clinical practice. The linkage dimensions included: (1) formalization, (2) intensity, (3) reciprocity and (4) standardization. The effectiveness variables included seven goals of practice for occupational therapy and physiotherapy. Results indicated that the nature of formalization between the Training Center and provincial hospitals was informal and low. The intensity of the relationship and degree of reciprocity between the Training Center and hospitals were found to vary from hospital to hospital. The overall effectiveness of clinical practice in each hospital was perceived to be "fair." Mutema (1981:6-7) concludes:

> Voluntary interactions may be characterized by informal agreements, low procedural standardization and varying degrees of intensity and reciprocity. Allied health programs which are considered ineffective by students may be considered effective by qualified health professionals. The third major conclusion drawn is that it was difficult to establish the impact of linkage dimensions on the effectiveness of clinical practice.

In another recent study, Andrews (1978) examined patterns of interorganizational linkages which existed in four preparation programs for respiratory technologists and related these to the degree of integration and overall program effectiveness. Using three linkage dimensions: degree of formalization, degree of intensity and degree of reciprocity between the focal organizations, Andrews investigated the relationship between these variables and program effectiveness. The study established that different measures of interorganizational linkage patterns are closely associated with different outcomes, in terms of objective measures of student performance on national exams and individual perceptual assessments of satisfaction with the program. High formalization, high standardization and high resource commitment were positively related to higher student achievement on a national examination. However, these variables were negatively related to student perceptions of program effectiveness.

O'Sullivan (1977) examined the value of interorganizational relations of voluntary associations by sending questionnaires to rape crisis centers in the United States.

Interorganizational cooperation was studied in its relationship to structural variations and organizational effectiveness. No relationship was found between cooperation and organizational structure or effectiveness. Turk (1973:37) conducted an extensive study of organizations and their interrelationships. The research focused on the influence of municipal government and community voluntary associations on the formation of hospital councils in 130 cities in the United States. The major finding was that

> ...the integrative significance of government and voluntary organizations may rest less on linking individuals to their environment, than upon linking organizations to one another, thereby supporting the feasibility of the interorganizational level of analysis.

With respect to coordination of vertical and horizontal activities, Benson et al. (1973) indicated that state rehabilitative agencies who justified their existence on the number of cases rehabilitated, found it necessary to refuse clients who require long treatment as these cases may give the agency the appearance of being unsuccessful. Warren et al. (1974) suggested that the philosophy of public administration should be shifted by encouraging competitiveness between social service organizations. One way of doing this would be to provide the disadvantaged with a social credit card for purchasing services from the program of their choice. Warren (1970) also argued that emphasis on increased coordination tends to direct attention away from the possiblility that new programs may be better.

Additional research has indicated that more highly structured linkage between organizations may result in fewer procedural problems affecting the interaction process. Reid's (1967) study of a coordination attempt between a school and a family service organization indicated that the relationship broke down largely because the school did not formalize its role. The agency staff reported that when they contacted the school, they were referred from one office to another seldom talking to the same person. Black and Kase (1963) reported that the principal reason for the success of a joint activity between a welfare department and rehabilitation agency was that each agency clearly specified their contact people for the inter-agency exchange.

In contrast, Litwak and Hylton (1962:400) conducted additional research concerning interorganizational relations. It was found that "highly formalized interactions can result in conflict between the organizations involved." One approach to the reduction of conflict between organizations is the development of some form of coordinating mechanism. The type of coordinating mechanism developed between the organizations is hypothesized to emerge from the interaction of three variables: (1) the degree of organizational interdependence, (2) the level of awareness, or need for the relationship and (3) the degree of standardization of the units being coordinated.

Summary

The literature review on interorganizational relationships has indicated that an investigation which examines the nature of interaction between organizations would be both interesting and useful. For the purpose of this study, it was decided that 'situational' and 'structural' dimensions proposed by Van De Ven and Ferry (1980) should provide categories to classify data regarding the delivery of clinical services. As well, dimensions in the model concerning the formulation and maintenance of interorganizational relationships have included 'outcome' factors which may be utilized to examine the perceived effectiveness of clinical service delivery.

Clinical Service Delivery

The literature in this area will focus on: (1) models of clinical service delivery, (2) issues and research related to the delivery of clinical services, and (3) the influence of the home environment. For the purpose of this study, the delivery of clinical services will be based on an open systems perspective utilizing Weick's (1976) conception of loosely coupled systems where the focal organization is engaged in interaction with organizations in the environment.

Models of Clinical Service Delivery

There are many models for the delivery of clinical services which focus on diagnostic, prescriptive and consultative services for students with serious learning and behavioral problems. Hardin (1978) described an ecological or total model which considers interaction of all relevant factors including the deficits and strengths in the student, teacher, classroom and home. Many variations related to delivery of clinical services have been reported by Bagnato and Neisworth (1979), Bailey (1976), Carberry (1977), Elstein (1977), Reith (1976) and Renee and Moore (1977). Contemporary standards of professional practice and recent legislation in the United States (Public Laws 93-380 and 94-142) have been emphasized by Scott (1979a and 1979b) to ensure appropriate clinical service delivery for children with special needs.

Administrative constructs for an integrated educational program to provide neuropsychoeducational services have been described by Singh (1977:1):

1. Institutional philosophical orientation affects educational programs in proportion to its directional orientation.
2. An educational program can be meaningfully interpreted only in terms of its organization as a total system.
3. It is the understanding of 'process' which leads toward awareness regarding the elements, interaction and overall dynamics of the program.
4. It is the organism-environment interchange which leads towards therapeutic communication.

Characteristics of clinical problem solving tasks have been discussed by Elstein (1977). Two major types of clinical models, the diagnostic and therapeutic, have been distinguished. In the therapeutic mode, the state of the system or the person is first identified then a remedy is chosen which is suited to the problem. In the diagnostic mode, the state of the system is identified only to the point where an action can be taken. Elstein (1977:4) advocates the therapeutic role, and states that, "the task of the clinician is to determine what action should be taken, not what the underlying state of the system is."

Models of clinical service delivery provided through an interdisciplinary team approach have been described by Bailey (1976), Irvine (1976) and Scheiner (1978). Because of the multi-causation factor present in children with severe learning problems, an interdisciplinary team approach focuses on the whole child in a single referral setting. The major activities in the approach include the following: collecting data on the student, conducting in-depth interdisciplinary study, developing composite diagnoses, providing treatment and diagnostic reports as well as implementing treatment plans. Bailey (1976:103) states:

> Consultation is an ongoing process where effective communication and collaboration are fundamental to the success of all operations. Diagnostic findings and prescriptive recommendations become useful when they are meaningful and acceptable to all who educate the child.

Guidelines for planning and evaluating models of clinical service delivery based on an organizational domain-referenced approach have been proposed by Maher (1980). Human, technological, informational and financial resources were considered input dimensions of the approach. A clinical system expends staff effort, delivers services and processes information with respect to output. A system transforms input to output by means of its service delivery which consists of the following interrelated sub-processes outlined by Maher (1980:61):

1. Needs Assessment. The process focuses on collecting and organizing information about psychoeducational needs of identified children.
2. Program Design. The process involves the planning, developing and implementation of individual and group special needs which result from the allocation of human, technological and financial resources.
3. Program Evaluation. The process concerns collecting information related to the outcomes of special service programs.

In order to determine the special needs of students, parents and teachers, Gezi and Broussard (1978) developed a comprehensive needs assessment. Data must be gathered concerning the cognitive, affective and psychomotor strengths and weaknesses of the student. Students must be comprehensively diagnosed in order to suggest recommendations for intervention. The most common needs of the student must be analyzed. Resources between the home and school must be identified to support the proposed program. Loven (1978) concluded there is a need for clinical specialists to act as liaison agents to promote collaborative problem-solving.

Issues Related to Clinical Service Delivery

The delivery of clinical services for students with behavior and learning problems has been found to lack adequate follow-up. Jacobs (1978) found that in only 61.1% of cases, psychoeducational test reports included recommendations for remedial activities. Only 27.6% of the teachers in this study found that assessments helped them deal more effectively with the child but that children were easier to work with when results had been explained to the parents. Ulman (1979) conducted a survey which indicated that 76% of the psychologists said they provide follow-up on all or most of the students, 89% used an informal follow-up system. However, Davis (1977) indicated that the minimal contact which teachers have with school psychologists leads to a lack of mutual understanding concerning the child.

Warren (1975) found the relationship between teachers and psychoeducational specialists was one of mutual distrust and mutual dissatisfaction and the communication between the teachers and specialists aimed at clarifying the problem was minimal. The limit to which teachers will accept parent participation in the children's education is often viewed as a problem. Warren's final finding was of particular worth. While teachers and parents share many values when they both converge on the child as a student, their vested interests often conflict and produce tensions not easily resolved through a shared value system.

In the final report of a project to demonstrate educationally relevant approaches for the assessment of handicapped children. Renee and Moore (1977:32) indicated that, "school personnel have a vested interest in the results of an assessment which implies both rights and responsibilities." Schools have the right to be involved in the evaluation process and expect that conferences will be scheduled at times which will not be disruptive to the school day. Results and recommendations should be communicated in writing as well as verbally assuming that parental consent has been obtained. Schools also have the right to expect that clinical staff will follow-up to determine the effectiveness of recommendations.

Health is a neglected consideration within most team approaches to remediation. Nivens (1979) described procedures and considerations for choosing, evaluating, and utilizing medical and psychological referral sources. Often, pupils are in danger of becoming a fragmented jig-saw puzzle while the parents define the problem from their viewpoint and school personnel apply remediation based on a conceptualization of their concern. Nivens (1979:1) states:

> At the onset of the consultation process, parents and school personnel should examine each and every unseemingly unrelated aspect of the difficulty, then reconsider conclusions incorporating each other's perspective.

A majority of the public school systems in the United States have policies that require one or two parent conferences a year. Kroth and Brown (1978) indicated that Public Law 94-142 requires parental participation in placement decisions and in the development of educational plans for each handicapped child. Carlson and Hillman (1975) recommended that the parents receive an explanation of test results and that the parents also receive suggested activities to do at home with the child. Many parents may be very anxious about school conferences and feel that voicing their complaints will make things worse for their child. When children obtain low grades or behave aggressively, parents almost automatically wonder what they have done wrong. Black (1979) suggested that home visits by clinical specialists may make parents feel more comfortable in terms of discussing their child's assessment results.

The effectiveness of clinical service delivery is facilitated or hindered by the nature of interaction between the parents and school personnel. When problematic situations arise, King (1979) and Loven (1978) found that parents or teacher may attribute the cause of the problem to the other party. Consequently, from the beginning, mutual problem solving efforts may be handicapped by defensive or angry feelings. Attributional egotism is a phenomenon where there is a definite tendency for teachers to share credit for success with students but distribute blame for student failure to the home conditions. Bar-Tal and Efraim (1979) concluded that teachers of elementary level students tend to attribute their students' successes to student effort and interest, their own quality of explanations and in part to the home conditions.

Influence of the Home Environment

Building a meaningful relationship between a family and school personnel is a major objective of clinical service delivery systems. Smith (1978) proposed that the principal, school psychologists, counselors and teachers must be viewed as resource people to consult with, on an ongoing, informal basis rather than experts who will supply the solution. Tucker and Bernstein (1979:83) state the outcomes of a family-systems approach in delivering clinical services:

1. A number of families whose children experience learning difficulties as well as dysfunctional family relationships are brought into successful therapy.
2. School personnel develop new insights and techniques in resolving learning problems that are a product of disturbed family relationships.
3. Interpersonal relationships are also modified among school personnel.
4. Many teachers are able to improve their classroom techniques with children whose behavior is disruptive in the learning situation.

In the family systems perspective proposed by Tucker and Bernstein (1979), symptomatic behavior of the child has been viewed in terms of the unique modus operandi of the whole family rather than focusing on the individual identified as the problem. Whenever several people are closely related, they automatically form a feedback system which in turn regulates and patterns their individual behaviors. Satir (1964) adopted the viewpoint that every member of the family is emotionally interrelated to every other member. Unresolved tensions will always be expressed in highly disguised forms. By its nature, the family is a social-biological unit which exerts a great influence on the child's behavior.

Schools of today are having difficulty dealing with new family structures. Alexander (1978) pointed out that the effects of parents and children in various family lifestyles leads toward changing ideologies with respect to academic achievement and authority structures. These changes influence the number of referrals with respect to clinical service delivery. Ricci (1979) and Schorr and Moen (1979) suggested steps the schools can take to ease the situation in cases where there is one parent who has custody of the child. Giele (1979) and Wattenberg and Reinhardt (1979) discussed the number of variant family forms and indicated that changes in the school system and society must occur to alleviate strain on the child.

As well, Bronfenbrenner (1979) postulated that social and economic trends tending toward the fragmentation of the family, threaten the personal welfare of parents and the well-being of children. It is important to families of young children to have support when problematic situations occur. Bronfenbrenner advocated strategies which build interconnections between the settings, so that families receive recognition in the contexts of the school, community and society. Such strategies call for the aid of clinical service delivery systems. Stroup (1978) believed there is need for a reasonable and stable political and economic structure to emphasize the importance of the family.

Parents, in general, are aware of their children's problems. McMahon (1979) found parental ratings on aggressiveness and social responsibility were compared through clinical staff diagnoses of 120 children. Results showed a consistent relationship on behavior disorder and hyperkinesis, indicating the potential usefulness of parent ratings as a tool in the interdisciplinary diagnosis of children with school-related problems. Barsch (1968) reported that developmental problems such as delayed speech and poor motor coordination are often observed by mothers very early in the child's life. He has suggested that the parent's inability to understand the educator's language results in a communication barrier that could delay needed services for the child.

Summary

The research which has been reviewed has indicated that various models of clinical service delivery have been implemented. However, communication between specialists and school personnel is a concern. Problems related to student health and the assessment of adaptive behavior have also been outlined. Influences from the pupil's home environment appear to indicate that there is increasing need for effective service delivery; therefore, contemporary schools have the responsibility of involving parents in the clinical process. The overall effect of clinical service delivery is open for investigation through an examination of interorganizational relationships.

Conceptual Framework

Within the framework of this study, the Diagnostic Clinic's service delivery system has been conceptualized as a social action system and the schools have been viewed as systems in the environment. Van De Ven and Ferry (1980:6) state that "the action system consists of an iterative series of choices regarding the organization's environment, people, money and a repetitive cycle of procuring and distributing inputs to outputs." The design of the social action system is constrained by the environment through the nature of referrals from the schools and by the cooperation of the pupil's family. Open systems theory suggests that relations among events cause processing of inputs to outputs. The Diagnostic Clinic must obtain clients (i.e., inputs) and deliver services (i.e., outputs).

Steers (1977:10) defines an open system as "a set of elements standing in interrelation among themselves and with the environment." Using this approach, the interactions between the Diagnostic Clinic and schools has been studied through the nature of interorganizational relations. Emphasis has been placed on the dynamic interrelationships which exist among the various components of the Clinic and the way in which the coordination among the clinic's subsystems affect the delivery of services to the schools. Interorganizational relations between the Diagnostic Clinic and schools may be studied as throughput or as a conversion process using the open system approach.

The throughput process has been related to the situational, structural and effectiveness dimensions proposed in Van De Ven and Ferry's (1980) model. A global measure concerning the effectiveness of casework has focused on the school personnel's judgment as to whether or not the relationship with the Clinic has been worthwhile, productive and satisfying. The situational dimensions proposed by Van De Ven and Ferry's (1980) model have been related to the Diagnostic Clinic's service delivery system as follows:

1. Resource Dependence. The school's need for the service of the Diagnostic Clinic has been related to the formation of interorganizational relationships.

2. Responsiveness to Problems. The Diagnostic Clinic's capacity to handle referrals is another dimension related to the formation of interorganizational relationships.

3. Awareness. The school's awareness of the goals and services of the Clinic also determines the establishment of an interorganizational relationship.

4. Consensus. In order to establish an interorganizational relationship, the Clinic and school personnel must agree with the objectives and recommendations proposed for the clinical assessment.

5. Domain Similarity. The degree to which clinical specialists have the same skills and resources as school personnel has been related to the necessity of developing an interorganizational relationship.

The structural dimensions of the interorganizational relationship proposed by Van De Ven and Ferry (1980) have been studied in the following manner:

6. Intensity. The school's reaction to communication with the Clinic has been studied through the nature of contacts which have been initiated.

7. Formalization. The referral procedures, case conference, final report and follow-up have been used as methods for maintenance of the interorganizational relationship between Clinic and schools.

8. Complexity. The roles and responsibilities of the Clinic staff and school personnel have been associated with complexity of the interorganizational relationship.

9. Centralization. The degree to which decisions are made by a central authority is related to centralization.

The assessment of effectiveness has been based upon the school personnel and parents' reaction to the casework completed by the Diagnostic Clinic.

10. Effectiveness. The effectiveness of the Clinic as perceived by school personnel has been examined through the reaction of principals, teachers, counselors,

field specialists and parents.

The framework of this study outlined in Figure 1 links the effectiveness of the Diagnostic Clinic's performance with the impact of the organization on schools as systems in the environment. The influence of the schools and the pupils' home background may be viewed as an environmental factor which influences the processing of client referrals. The selection of literature and the method of analyzing the coordination system recognize the importance of field specialists who are boundary spanners screening the referrals from the schools to the Clinic. The study will not focus on a small set of variables at one particular level of analysis but will be derived from an interunit model proposed by Van De Ven and Ferry (1980:9) which provides criteria for the analysis of interdependence, coordination and functioning between organizations.

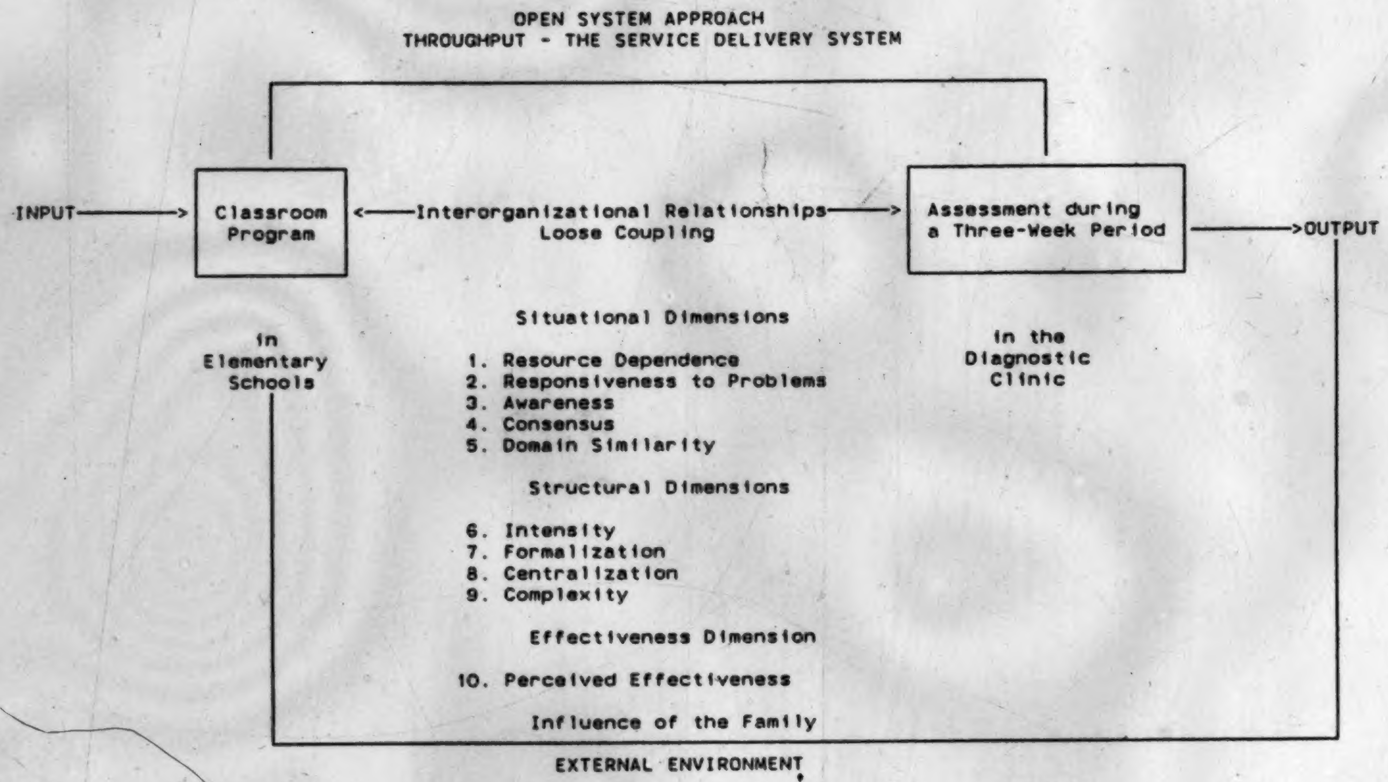

Figure 1

Conceptual Framework for the Study of Interorganizational Relationships and a Clinical Service Delivery System

Chapter 3

RESEARCH METHODOLOGY

The research methodology presented in this chapter will be based on the case study method, participant observation, semistructured interviews and content analysis techniques. The pilot project and details related to data collection will also be described. Finally, the trustworthiness of qualitative data will be discussed in relation to the study.

The Case Study as an Investigative Method

The dialectics of the case study have been outlined by Haymond (1980:5) who recognized three levels of analysis: (1) Macro dimensions include data such as the relationship between language and culture, sociopolitical atmosphere and racial conditions; (2) Molar dimensions have been used to describe organizations and noninstitutionalized units such as the family; (3) Micro dimensions are factors which affect the individual personality and may emerge from a biological context. In the development of this research, molar dimensions became fundamental elements in the study of interorganizational relations and micro dimensions provided a basis for the description of client referrals.

Based on the principles of dialectics, Reigel (1979) outlined five coordinates which tend to influence the results of a case study: (1) the process-oriented nature of the case study as opposed to the mechanical, (2) the human relationships between the researcher and the respondents of the case study, (3) the descriptive aspect of the case study as opposed to the predictive, (4) the integration of the psychological within a sociological framework and (5) the dynamic interplay of theory and practice.

Through application of dialectic principles described by Rappoport (1978), a process oriented case study has been found practical in the design of this study. Dialectic methods have emphasized natural life situations for observing and describing as opposed to highly artificial laboratory situations. During a three month period, the researcher spent sixty hours interacting with respondents who were associated with children referred to the Diagnostic Clinic. The researcher viewed all aspects of the service delivery system allowing findings to develop as a consequence of observation.

This research has therefore been based on description and induction through use of qualitative data and the case study method. Stake (1978) indicated that when the aims are understanding, extension of experience and increase in conviction in that which is known, the case study method becomes appropriate. The case study focuses on knowledge as a form of generalization arrived at by recognizing the similarities in issues and by sensing the natural covariation of happenings. Case studies feature descriptions which are holistic and involve a myriad of variables gathered at least partly by participant observation. Stake (1978) also indicated that the writing style of the case study report may use narrative as well as verbatim quotations as illustrated in the text of this study.

Participant Observation

Spradley and McCurdy (1972) characterized participant observation through social interaction between the researcher and the respondents in the milieu of the latter. The purpose of this study was to examine the nature of interorganizational relationships between the Diagnostic Clinic and schools; consequently, it appeared logical for the researcher to assume the role of participant observer. The researcher accompanied clinical specialists as they carried out casework and selective observations were made through use of field notes and tape recordings.

Entering the Field

In order to engage in research of this nature, permission was obtained through the Department of Research and Design at the Oak View Public School Board (OPSB). Approval was granted by (1) completing an application form to engage in the Cooperative Activities Program organized between the University of New Durham and OPSB, (2) meeting with the Supervisor of Childhood Services, at the OPSB to gain permission to observe personnel at the Diagnostic Clinic and (3) attending a staff meeting at the Diagnostic Clinic to obtain acceptance from the Clinic staff. A subsequent meeting was arranged with the diagnostic teacher at the Clinic in order to become acquainted with the nature of the service delivery system. Information was obtained regarding the testing schedule at the Clinic. Times and dates were set for team conferences and liaison with school personnel. The role of participant observer was delimited by focusing on particular respondents in the research setting.

Selection of Respondents

The major respondents were the four clinical specialists and diagnostic teacher who volunteered to participate in the project. As well, the four case studies focused on the first four children referred for a designated three-week assessment period between April 15 and May 15, 1981, at the Diagnostic Clinic. Each pupil's teacher, principal and counselor was contacted and all agreed to cooperate with respect to the study. The four pupils as well as the clinical specialists were observed during a two-month period at the Diagnostic Clinic and follow-up interviews with school personnel were conducted throughout the following month. A three-week period transpired between the participant observation at the Clinic and the semi-structured interviews with teachers, principals, and parents of the four pupils. A description of the four case studies may be found in Appendix A.

Obtaining Consent for the Case Studies

The entire staff at the Diagnostic Clinic volunteered to participate; however, the problem of obtaining written consent from the parents whose children would be engaged in the project was paramount. Because some parents harbor animosity toward school personnel, the clinic specialists felt that a great deal of caution would be required to ensure that the Clinic referral would not be sabotaged by the research project. The social worker felt that it would be best to obtain parent consent on the initial home visit. The researcher accompanied the social worker on each intake home visit concerning the target pupils. A consent form was signed by each of the four parents who agreed to participate.

Pupil Files and Clinic Records

Complete copies of pupil files concerning the four case studies were xeroxed. Each file contained previous reading assessments, social histories and psychology reports. File notes, background information as well as audiometric test results, medical reports and psychiatric assessments were included in each file. Upon termination of case work, the Diagnostic Clinic's final report was also added to each file. Appendix B contains a sample of this document. The referral form, intake summary information and teacher report forms were other records which were collected and have been included in Appendix C.

Recording Field Notes

Field notes were recorded on a small note pad and focused on various interactions, climate, unusual episodes, reactions of clinical specialists and salient points obtained in meetings, case conferences and on home visits. These notes were used as a cross-check for the tape recordings of meetings, case conferences and home visits. Along with more elaborated reactions to the researcher, the notes were dictated into a tape recorder and transcripts were typed by a secretary. Several examples of field notes may be found in Appendix D.

Use of Tape Recordings

The researcher obtained all written documents related to each of the four case studies of pupils and made arrangements to attend the final case conferences when test results were interpreted to the parent and school personnel. At the first case conference the usefulness of recording and transcribing group meetings was tested. A brief explanation of the need for taping the session was made and confidentiality was ensured. There were no objections on the part of the Clinic staff or school personnel with regard to taping the session and the conference resumed without further interference. The tape recorder was found to be an effective and unobtrusive device for capturing verbatim data. It was decided to record and transcribe all meetings, conferences and interviews related to the study. The transcript of a meeting is included in Appendix E.

Role of the Participant Observer

Spradley and McCurdy (1972) indicated that the role of the participant observer enables the researcher to catch the process of interpretation through immersion in the social situation being investigated. Participant observation appeared to be an appropriate method to collect data for this study. One of the merits of systematic participant observation was the opportunity to observe respondents in their context. In using this methodology the researcher may be able to discover subtle or implicit interrelationships which occurred between the Clinic and schools. McGuire and Bashook (1978:29) conclude that "a set of problems must be selected which sample the total universe defined in terms of three dimensions: content, nature (processes) and context of setting."

The Interview as an Observational Technique

The importance of the interview as more than a simple technique has been expressed by Hyman (1954:6) who described the interviewer as the "human middleman." The interview has also been considered an excellent observational tool by Pelto (1970) who indicated that most primary data in the social sciences comes from three sources: directly observing behavior, listening to and noting the contents of human speech and examining the products of human behavior. Pelto (1970:9) believes that the interview is a process through which the researcher may "convert the stuff of raw observation" into abstract conceptual structures. The semi-structured interview has been chosen as a logical technique in terms of its adequacy in meeting Pelto's criteria for successful description.

Travers (1964:228) discussed the unstructured interview in which "the conversation is left to wander where it will" as opposed to the structured interview which proceeds with a list of standardized questions. In this regard, Piore (1979:560) states "either I let the respondent tell his story using my questions as an excuse or I force him to treat questions seriously with a codeable response." In this study, semi-structured interviews were conducted with ten field specialists, ten principals, ten teachers and ten counselors. The interviews varied in the extent to which they were structured allowing the researcher to understand the respondents' perspectives concerning the Education Clinic's service delivery system.

The Interview Guide

An interview guide consisting of ten questions was used to gather in-depth information related to the Diagnostic Clinic's service delivery system. The interview guide which may be found in Appendix F was developed in the following manner. Van De Ven and Ferry's (1980:308) model provided a focus for questions which were based on situational, structural and effectiveness dimensions of a service delivery system. The review of literature in the area of clinical service delivery provided background for developing questions related to the effectiveness of the Diagnostic Clinic. Three field specialists who were experienced in working with personnel from the Diagnostic Clinic were consulted regarding the appropriateness of the interview questions. On the basis of comments from these people, a set of thirty-three questions was developed.

The Pilot Project

A pilot project which focused on an individual case was conducted by gathering all pertinent data concerning a student's referral to the Clinic. Using the thirty-three questions, interviews of the student's counselor, teacher and principal were taped. The technique of probing for more in-depth information was used to obtain a better understanding of the respondents' answers. It was discovered that too many questions were asked and the researcher therefore reduced the interview questions to cover ten global areas. The ten new questions were open ended to ensure that respondents could present various points of view.

Validation of the Interview Guide

In order to determine content and face validity of the interview guide, the respondents in the pilot project were requested to clarify or criticize the ten questions. Specifically, the respondents were asked to determine the extent to which the questions represented the content for which they were designed. Each respondent was familiar with the Diagnostic Clinic's service delivery system and the respondents indicated that all questions appeared valid and relevant. After the ten revised questions and answers were taped in a subsequent interview with a field specialist, a transcript of the interview was typed to determine whether responses could be coded according to Van De Ven and Ferry's (1980:308) model. It was possible to classify the data using content analysis although some of the responses were classified as not applicable.

Preparation for Interviews

Interviewing is a technique which requires appropriate training and guided experience as essential background. The researcher developed a set of carefully prepared questions which were written on a set of ten 3 x 5 inch cards. The respondents were able to refer to these cards as the interviews progressed although the order of presenting questions varied at times to adapt to the circumstances of individual interviews. The researcher received training with respect to interview techniques in Educational Psychology 512, a course which was completed in the Department of Educational Psychology at the University of Alberta.

The Interviews

Using the interview guide, ten field specialists were interviewed during the latter part of the 1981-82 school term. A list of sixty field specialists was obtained from the Oak View Public School Board and the first ten respondents who were contacted agreed to be interviewed. Anonymity was assured and the interviews were arranged at a time and place suited to the respondents' convenience. Three of the ten interview transcripts were returned to field specialists who signed a document indicating that the transcript was a verbatim copy. The following school term, ten principals, ten teachers and ten counselors who referred clients to the clinic were also interviewed. A Sony tape recorder (TC 110b) was used and the interviews were transcribed by a typist.

The Respondent Questionnaire

A respondent questionnaire was given to twelve of the forty respondents who were interviewed. A five point Likert-type scale was used to determine the reaction of the respondents. The rating scale is listed as follows: 1 = strongly agree, 2 = agree, 3 = disagree, 4 = strongly disagree, 5 = do not know or no opinion. Results of the questionnaire indicated that the interviews were a valid method of collecting data for this research project. The following results represent a mean of the responses which were obtained regarding the semi-structured interview.

Table 1

The Respondent Questionnaire

		Mean
1.	I understood all the questions.	1.67
2.	My answers were frank.	1.17
3.	The questions were biased.	4.08
4.	The interviewer appeared neutral.	1.75
5.	The questions were adequate to cover the variables and issues.	1.58
6.	I answered each question as honestly as possible.	1.00
7.	The interviewer gave me ample opportunity to express my opinion.	1.00
8.	The questions were fair and free from prejudice.	1.33

Content Analysis

Content analysis has been defined by Berelson (1971:18) as "a technique for the objective, systematic and quantitative description of the manifest content of communication." According to Stone (1964), content analysis may be used as a procedure for assessing the relative extent to which specified references, attitudes, or themes permeate a given message or document. Lasswell (1949) suggested that content analysis is a technique for the classification of data which relies solely upon judgments based upon perceptions. An analyst or group of analysts may categorize data on the basis of explicitly formulated rules, provided that the analyst's judgments are regarded as the reports of a scientific observer.

According to Stone (1964), content analysis may be used as a procedure for assessing the relative extent to which references or themes emerge from a given message or document. Berelson (1971:18-21) outlined certain assumptions which underly content analysis. Content analysis assumes that the manifest concept is meaningful. The content analyst assumes that meanings ascribed to the content will be understood by the audience. Through use of content analysis, quantitative description of communication content is possible. Lasswell (1949:59) states:

> The analyst's operations involve simple perceptual discriminations: determining the presence or absence of a given physical configuration and counting the number which are present. Hence no special validation procedures are necessary.

In this study, forty interviews provided data to classify information related to the interorganizational relationships which occurred between the Diagnostic Clinic and schools.

Using content analysis to classify data, reliability may be viewed through the process of communication as other researchers must be able to recognize the referent from the investigator's descriptions or coding instruction. In order to code interviews in this study, the first five categories focused on Van De Ven and Ferry's (1980) situational variables, categories six through nine focused on structural variables and category ten focused on effectiveness. A sample interview which has been categorized may be found in Appendix G. A doctoral student in the Department of Educational Administration was asked to classify three interviews according to the above categories.

The reliability of the content analysis system used in the interviews with forty respondents was measured through the Scott coefficient cited by Flanders (1966:13). The index of reliability corrects not only for the number of categories but also for the probable frequency with which each is used. The Scott coefficient is:

$$\text{Reliability} = \frac{P_o - P_e}{100 - P_e}$$

P_o represents the agreement between the two observers and P_e represents agreement by chance between two observers. Tuckwell (1980:12) cited 0.70 as an acceptable level of reliability. The intercoder reliability established for categorization of the interview data in this study was 0.70 and the intracoder reliability was 0.82.

McClintock et al. (1979:613) outlined the case cluster method which is an approach for analyzing qualitative data. The definition, enumeration and sampling of units should be theoretically meaningful, representing the phenomenology of informants. Data sources should be based on stratified sampling and standardized categories should be used to analyze variables pertaining to each unit of analysis. The case cluster method which has been used in this study features participant observation, in-depth interviewing and repeated contact with informants. Enumeration of units used for content analysis has been based on Van De Ven and Ferry's (1980) model and stratified sampling was used in selecting the principals, teachers and counselors who made referrals to the Clinic.

Trustworthiness of Qualitative Data

A central issue in research which uses qualitative data is the issue of validity. Van Maanen (1979) suggested that the whole aim of such research is a valid interpretation of the world as perceived by its inhabitants. Since the focus of this study has been based upon the perspectives of respondents, Greenfield's (1980:30) comments must be considered:

> It remains to be seen how men may perceive a criterion of truth that lies outside the workings of their mind and how they may express it without coloring and distorting it as they do everything else they perceive. It remains to be seen whether they would accept such a standard even if they were convinced it existed.

Faced with these difficulties, Greenfield finds it both reasonable and humane to question empirical facts or generalizations which the human mind has not worked on in some way.

Criteria for judging the trustworthiness of subjective data have been outlined by Guba and Lincoln (1981). The four major concerns relating to trustworthiness are truth value, applicability, consistency and neutrality. In establishing truth value, the researcher must be concerned with testing the credibility of findings and interpretations with the various sources and groups from which the data were drawn. In this study, sixty hours of participant observation occurred during a three month period of engagement. As illustrated in the appendices, information in the pupil reports and Clinic documents confirms findings obtained during the period of participant observation. Three clinical specialists validated data obtained during the period of participant observation and three field specialists validated interview data.

Applicability refers to the degree to which findings of a particular inquiry may be relevant in other contexts with other respondents. To determine the degree to which transferability is probable, it is essential to know about the transferring and receiving contexts through what Geertz (1973) has called 'thick description.' In this study, the detailed description presented in Chapter 4 and Appendix A concerning the service delivery system may provide adequate data for contextual comparison. The respondents involved in the study were familiar with the Diagnostic Clinic's service delivery system and it is possible that their perspectives may be applied to other service delivery systems. Guba and Lincoln (1981:13) state the researcher "forms working hypotheses that may be transferred from one context to another depending on the fit between the contexts."

Guba and Lincoln (1981) also indicated that the concept of consistency implies not invariance but trackable variance which can be accounted for through information which has been obtained from various sources and artifacts. The methods for collecting data in this study have been overlapped through participant observation, use of interviews and collection of referential materials such as documents and transcripts. A dependability audit has been arranged by having a member of the thesis committee comment on the degree to which the design and procedures in this study have reached an acceptable level of research practice.

Neutrality is commonly termed objectivity in the rationalistic paradigm. Guba and Lincoln (1981) indicated that neutrality is established by the degree to which the findings of an inquiry are a function of the respondents and conditions of the inquiry and not of the biases of the researcher. Scriven (1972) warned that the qualitative researcher must be aware of this problem due to the fact that multiple realities must be acknowledged. In this study an attempt was made to shift the problem of neutrality from the researcher to the confirmability of the data. As already noted, data have been collected from a variety of perspectives, using a variety of methods as well as sources.

Summary

The research was conducted at the Diagnostic Clinic in Oak View, New Durham. A school psychologist, a speech pathologist, a reading specialist and a social worker were observed in the process of delivering clinical services. Four case studies of elementary school pupils were carried out in order to focus on the service delivery system and liaison between clinic staff, schools and parents. The impact of clinical service delivery was determined through interviews with the parents, teachers and principals of these pupils. Additional information concerning the nature of interorganizational relationships was obtained through interviews with ten field specialists, ten principals, ten teachers and ten counselors who referred children to the Diagnostic Clinic.

Chapter 4

THE SETTING

In this chapter, a description of the setting will be presented to provide an understanding of the service delivery system among the Clinic and schools. Characteristics of the setting which are related to the background, operating procedures and personnel in the Clinic will be presented. Organizational problems and the solutions proposed by the staff will also be described. All names of persons and places in the narrative have been changed to ensure anonymity of the respondents.

Background

From the viewpoint of Van De Ven and Ferry (1980), it was necessary to look at the mandate of the larger organization, the Oak View Public School Board (OPSB), to examine the interorganizational relationships between the Diagnostic Clinic and schools. The philosophy of the OPSB has been to develop the unique potential of each student to the fullest. The annual OPSB Report stated that the major goal of the public schools has always been to match the needs, abilities and learning style of the individual student with the most appropriate learning experience.

The OPSB has advocated the economic use of resources to place students in the least restrictive environment. As early as 1948, it was recognized that students with severe learning problems required special services. At that time the position of "visiting teacher" was created to provide intensive casework and consultation for the schools. In 1955, the first social worker was hired to deal with pupils' behavioral difficulties and attendance problems. The importance of the social worker was realized based on the rationale that children may suffer from various social and emotional difficulties which impede or block their ability to constructively use the opportunities offered by the school.

As the school system expanded, it became recognized that there were many children who required specialized assistance for learning difficulties, as well as behavioral and personality problems, which could not be handled by existing resources. In order to deal with these problems, the Childhood Studies Bureau was created in the 1960's consisting of interdisciplinary teams composed of a psychologist, social worker, reading specialist and a speech clinician. These teams were designed to provide support to the schools to develop remedial plans for pupils and to serve as a linkage agent for outside community resources. The primary function of the interdisciplinary teams was to more adequately meet the needs of parents, teachers and students who were not profiting from available instructional opportunities.

In 1980, the Childhood Studies Bureau adopted a new title, Assessment Services. Assessment Services were composed of twelve interdisciplinary field teams who had privileges for referring children with complex problems to the Clinic. The Clinic was created in 1967 as a resource to aid field specialists. The Clinic provided in-depth assessment and recommendations for children who were observed and treated in the context of both the family and school situations. Based on the principle that early prevention is the best use of resources, the Clinic dealt primarily with elementary school children.

Description of the Clinic

The Clinic has been housed in an elementary school which is located in a lower middle class area of a metropolitan city. The center serves all of the schools in the Oak View Public School system. From 1977 until 1981 an average number of sixty-two in-clinic assessments have been completed each year. Transportation for the students who must travel from the various parts of the city was funded by the OPSB. A school bus picked up each child at his home and delivered the child to the Clinic. The child returned home during the noon hour each school day. Some parents, particularly those in the northern part of the city, complained that there had been mornings when the child had spent over an hour travelling on the bus.

The Diagnostic Clinic dealt primarily with children from grades one to six. Requests for the Clinic's services generally exceeded the capacity of the facility and cases were often placed on a waiting list. The clinical staff were concerned with diagnoses, prescribing programs, special class placement, teacher consultation, parental counselling and when required, referral to 'outside agencies.' The major objective of the service has been to conduct in-depth study of children who present multiple learning problems thererby requiring extremely detailed and long-term educational planning.

Intensive assessment and proposed remediation were conducted by an interdisciplinary team composed of a psychologist, social worker, speech and hearing clinician and a reading specialist. A diagnostic teacher and secretary were also members of the Clinic staff. The student's period of stay at the Clinic was generally three weeks from 8:45 until 11:45 each day. During the assessment period, diagnosis by all four disciplines and on-going observation by the diagnostic teacher was carried out.

Operating Procedures

The term formalization refers to the use of rules and procedures in an organization. Within the structure of the Clinic, operating rules and regulations were developed by the professional staff. The Pupil Assessment Service Handbook outlined the operating procedures of the Clinic although these procedures have been open to change. The staff was free to schedule their own timetables and carry out activities without direct supervision. The following were the operating guidelines which determined the nature of the relationship between the Clinic and schools.

Intake

Initially, school personnel, usually the school counselor or principal, referred the student to the field team for an opinion. After determining whether the referral was appropriate for the Diagnostic Clinic, a field specialist contacted the diagnostic teacher at the Clinic. A date for placement was specified and parent consent for assessment of the child was obtained by the field specialist who made the referral. The week before the student entered the Clinic, a home visit was arranged by the Clinic social worker in order to obtain information regarding the student's background.

The Case Coordinator

A specialist from the Clinic was assigned as a case coordinator for each case. It was the case coordinator's task to send a letter to the school principal stating the date of the student's admission to the Clinic. The case coordinator obtained data regarding the student's academic progress and behavior during a school visit which occurred the week before the student entered the Clinic. At that time, the case coordinator introduced herself to the student who was then briefed about the transfer to the Diagnostic Clinic. An "intake Summary" was prepared by the case coordinator and a "Teacher Report Form" was obtained from the classroom teacher before the student entered the Clinic (Appendix C).

The Casework Plan

The student attended the Clinic each morning for a three-week period. Subsequently a three-week casework plan was developed to facilitate service delivery. The first week was a period of adjustment and provided the diagnostic teacher time to make anecdotal records concerning the student's behavior. During this week, the diagnostic teacher observed the work habits of the student. At a Clinic case conference during the student's first week of observation, the social worker reported on the information concerning the student's background.

During the second week, an intensive testing schedule was implemented. The child's needs were assessed through use of IQ tests, speech and language tests and through various measures of reading and arithmetic achievement. The student's parents were invited into the Clinic to observe and discuss initial findings. At a case conference held the second week of the assessment, the diagnostic teacher and the four clinical specialists compared test results and plans for remediation and/or treatment were developed.

During the third week, remedial techniques were piloted by the diagnostic teacher in the Clinic classroom. The regular classroom teacher and counselor were often invited to observe the student. At the case conference held during the last week of the student's assessment, details such as recommendations regarding the home, possible therapy and remedial programming in the classroom were discussed to prepare for the student's discharge.

Discharge

After the student was discharged, the case coordinator contacted the classroom teacher regarding suggestions and techniques for implementing remedial procedures. Each clinical specialist completed an individual assessment report. The second week after the student was discharged, the secretary at the Clinic typed the reports of the four specialists and the reports were distributed to the school and field specialists. A final case conference was held the third week after the student was discharged and test results as well as recommendations were discussed at the student's school. In addition, the clinical specialists met with the parents to discuss findings. Follow-up was scheduled for a period of one year.

The Clinical Specialists

Within the Clinic, five disciplines represented the occupational specialties of the clinical staff. Since each contact with schools involved an interdisciplinary assessment, it was necessary for the social worker, psychologist, reading specialist and speech pathologist to integrate their efforts. As well as coordinating efforts of the team members, liaison with schools, parents and outside agencies was essential. An average of sixty-two cases were processed each year by the clinical team. The following is a description of the psychologist, reading specialist, social worker, speech clinician and diagnostic teacher.

The psychologist

The psychologist was assigned to the Clinic to perform intensive case studies of client referrals through use of intelligence, personality, aptitude and other tests. It was the role of the psychologist to appraise the student's socio-emotional adjustment.

Program plans were developed on the basis of assessment results. In addition, the psychologist conducted clinical studies preceding any Special Education placement. The psychologist provided short term counselling to clients, maintained liaison with the classroom teacher and conducted reassessments as needed. This was the psychologist's first year at the Clinic. The psychologist describes her background to the researcher.

> Psychologist:
>
> I suppose in describing myself, I conceive myself to be a patient person, a person who can delay gratification a lot, somebody who has always been interested in children. I went into teaching as my first career. That isn't quite so, because I spent a little time at nursing which is also in the helping professions.... But, I did go to college at the normal age and I've taught altogether for fifteen years and was encouraged to go into counselling. (5.7.81)

The psychologist initially wanted to be placed on a field team as she indicated there may be more contact with the schools. However, once involved in her job at the Clinic, she stated that the Clinic position was important, particularly since there was an opportunity to engage in intensive work with parents.

> Psychologist:
>
> From my point of view, the most important part of its role is being almost a third party for parents and I think they accept our suggestions much more readily than if they felt we were somehow, someway, attached to the school the way field teams are. I know that from past experience, from being in the schools that there are long term benefits of Clinic that nobody realizes.... I find the job here important. I take it very seriously. (5.7.81)

The psychologist was concerned about the many hours of work required for her job. She indicated that there were very few evenings throughout the year which were not spent perusing files, scoring test protocols, and writing reports at home. In the psychologist's opinion, the work load at the Clinic was disproportionate to the amount of time available for the job and she stated that there was a need to restructure the service delivery system to allow more time for report writing and other clerical work. The psychologist was asked to describe her qualifications.

> Psychologist:
>
> O.K. Well I took my Master's and then I finished my Doctorate a year ago last April and I got scholarships all the way through. I did a fair amount of testing before I came into the Clinic in the school setting.
>
> Researcher:
>
> You are one of the most highly qualified psychologists who has been hired by

> the Bureau and you feel the workload is disproportionate to anything a person could bring to this job.
>
> Psychologist:
>
> I do feel that's true because I know that I've been called a workaholic and that I guess if I feel that the work is beyond what I can physically cope with, that there is probably something wrong with the organization. (5.7.81)

The Reading Specialist

The reading specialist's tasks included the diagnosis of specific learning disability cases, particularly those involving reading, arithmetic and spelling difficulties. The reading specialist developed plans for remediation, carried out diagnostic teaching sessions with pupils and assisted the teacher in implementing recommendations. In addition, the reading specialist arranged tutors for students and provided materials to support language arts instruction. This was the reading specialist's first year at the Clinic. She describes her background:

> Reading Specialist:
> I did have ten years teaching experience in elementary schools working with students from grade two to grade six and during that time, I was involved with students at both ends of the scale. My first three years of teaching involved a team teaching setup, where, depending on the year, there were four members on the team and one year we had six. Within the team teaching situation, it was allowed for professional sharing of ideas but it also allowed you to teach to different types of children because the children were streamed. (5.8.81)

The reading specialist obtained her Master's degree and worked five additional years in the area of reading and language arts. She planned to enroll in the Doctoral program in the area of reading curriculum. In the reading specialist's opinion, a great deal of experience was required to be an effective member of the Clinic team. She stated that otherwise it may be very easy for the clinical specialist to lack credibility with classroom teachers.

> Reading Specialist:
>
> Well, I really feel that someone coming to this position in the Clinic ought to have considerable background as a teacher. And I also feel that you need to have a very good feeling of what is required, not only just in reading but the whole language arts. Otherwise,I think you lack credibility in making suggestions because it would be very easy to be a little ivory-towerish.... Most teachers in our system are really very competent. Most of then have a B.Ed. degree and many years of teaching experience. I think if a child is experiencing difficulty in the classroom, if the teacher has really tried and it's passed on through the field team and eventually reaches the Clinic, I really think that we have to have quite a level of expertise to first of all feel comfortable. (5.6.81)

There was concern regarding the service delivery system and operating procedures at the Clinic. The reading specialist stated that too much of her personal time was spent writing reports, summaries and file notes at home. Workload and scheduling of conferences, school visit and team meetings seemed to be major problems. As a result, changes were proposed with respect to the Clinic's organizational structure. The reading specialist revealed her feelings concerning the Clinic position.

Reading Specialist:

> The job from September up to now has been more of a commitment than a job in the sense that this is my sixteenth year with the system and I don't think I've ever worked so hard and felt so behind all the time. I'm never caught up and when I say working so hard, I would say that I work on the average for sure of three nights a week and a large part of the four and it's very seldom that I have not written over the weekend. The difficulty is that you're involved with the children most of the morning, five days a week, and we recently have had meetings scheduled for two afternoons and sometimes if it involves a team meeting, it's a third afternoon. (5.8.81)

The Social Worker

The social worker was assigned to the team to study and evaluate the total social environment of the pupil. The social worker arranged the home visit as well as transportation for the student to travel to the Clinic. In addition, she contacted the parents for a visit to the Clinic. Play therapy sessions were conducted with the student and brief counselling sessions were conducted with parents. The Clinic social worker describes her background.

Social Worker:

> Well, academically, my first career was nursing. I went through the old three-year program and I specialized in obstetrics. And then I was out of the work force for seven years while I was raising my boys. I then went back to work as Educational Director for Planned Parenthood (5.12.81)

The social worker obtained her Master's degree and began working for the Oak View Public School Board. She was assigned to a field team position before obtaining a position at the Clinic.

The social worker discussed the time constraints which prevented ongoing counselling or family therapy at the Clinic. The objective of the Clinic assessment was to identify the student's problems, make recommendations to school personnel and refer clients to a community agency for follow-up therapy. The social worker stated that Clinic personnel developed rapport with parents; however, there was no opportunity for family counselling. In order to deal with this problem, she proposed that the Clinic caseload for the school term be reduced.

Social Worker:

> Well, if that's possible, I would certainly see what I could do about picking, say we had fifty kids, and I could pick, oh, ten would be a rational number. It would depend on the problems over the course of the school year, you could probably work rather intensively with ten kids and their families. Short term intervention might be effective. (5.12.81)

The Speech Clinician

The role of the speech clinician was designed to assist teachers in planning class activities for speech improvement and language development. The speech clinician conducted assessments concerning the speech/language problems of students and arranged referrals to outside agencies for cases requiring ongoing therapy. The speech clinician was able to provide therapy for only a few of the students referred to the Clinic. Details related to the speech clinician's background experience are outlined.

Speech Clinician:

> I've worked in this Clinic for two periods actually. This latest period has either been three or four years. And prior to that, I had two years when I was working on a field team part time, but was teaching in the morning. I had chosen to do that because the principal invited me and I had so little classroom experience. I was really quite worried about lack of familiarity with classrooms and whether or not I was asking teachers to do something that was practical or not. I was quite delighted to be asked to join the Clinic staff. I had come to Oakview in 1969 and worked for three years in a very colossal position in that when I first arrived, I was the speech pathologist for the north side of the city. (5.14.81)

The speech clinician expressed her pleasure in being part of the Clinic staff. She had nine years of experience conducting therapy in Australia and indicated that a clinical setting suited her best. She stated that she enjoyed the prolonged contact with the children at the Clinic and observed that the children appeared to be quite comfortable in the Clinic setting. The speech clinician mentioned that she always prepared the children for coming to the Clinic. When the speech clinician acted as case coordinator for a student, she stated that she would visit the classroom and present the Clinic assessment to the student in a very positive manner.

The Diagnostic Teacher

The diagnostic teacher provided the clinical specialists with information concerning the student's learning style by observing and making anecdotal records in the classroom. She recorded daily observations on each student and prepared written reports of these observations. Behavior modification plans were developed for particular cases. The diagnostic teacher implemented recommendations of the specialists within the Clinic setting and contacted classroom teachers to discuss observations. The diagnostic teacher was also responsible for the intake of cases. Following is a description of the diagnostic teacher's background.

> Diagnostic Teacher:
>
> I had an Arts degree in sociology and psychology and couldn't get a job. I took a year of Education and really was not interested in teaching regular class children so I applied for a Special Education position and taught a Primary Opportunity class for four years. I asked for a transfer as a result of having worked with two Ph.D. students who used my classroom as a place to implement behavior modification techniques, so I became quite skilled in handling behavior problems and had a reasonably good reputation. When I requested the transfer, it just happened that the Clinic position was available, so it was offered to me. Here I am.
>
> Researcher:
>
> And how long has this Clinic been established?
>
> Diagnostic Teacher:
>
> This particular Clinic is in its eighth year. THere are things I really like about working at the Clinic, for example, the flexibility. Also I like working with the specialists. I find perhaps they're not quite as narrow as a bunch of elementary school teachers. (5.11.81)

With respect to liaison with the schools, the diagnostic teacher attended more case conferences in the past than present. She stated that it was very annoying to make suggestions to the classroom teacher who would often say "I have twenty-six or twenty-eight children and those things aren't workable in my situation." The diagnostic teacher indicated that this type of response made her angry as suggestions were made with a large group of students in mind. She also indicated that the classroom teachers should be more flexible and not expect the student to be "changed" by the three week assessment. Other problems such as scheduling, time constraints and report writing were acknowledged.

> Diagnostic Teacher:
>
> Well, I have been here the longest of anyone. In the seven years that I have been here, it seems that whenever someone else joins the Clinic they have a lot of suggestions and we often implement them. However, it's a circle. What is implemented over one year and seems like a good idea, the following year when someone else comes in, we often implement another new idea that takes us back to where we were initially. There are problems at the Clinic, but I think it's just the nature of working at the Clinic, the scheduling, not having enough time, report writing. I just don't know how you overcome a lot of those things. (5.11.81)

Organizational Changes

The specialists, particularly the psychologist and the reading specialist, indicated there was insufficient time to do an adequate job at the Clinic. Time consumers which were mentioned included pre-admission school visits, comprehensive report writing, and the intake summaries. The number of meetings was overwhelming as the weekly schedule included one intake and one discharge meeting, at least two school conferences, and two home conferences. Follow-up and special meetings added additional pressure in terms of time constraints.

> Researcher:
>
> You've already mentioned that there's a great deal of pressure due to a very demanding job. Is there anything else you wanted to add?
>
> Reading Specialist:
>
> Uh huh. Really in the area of follow-up. I've been scrambling all year with ideas of how to more effectively and efficiently tackle the difficulty and even when I schedule follow-ups in my calendar, something just overrides them all the time. And just coming back to the lack of personal time, when I say that something overrides it, we're always in a situation where we are taking into consideration at least three other team members and maybe the diagnostic teacher. (5.7.81)

The reading specialist emphasized that follow-up had always been a serious concern of the Clinic staff as she had discussed the matter with people previously employed at the Clinic. She pointed out that follow-up should be a two-way communication between the Clinic and the schools. The schools were given the Clinic phone number on the case coordinator's initial visit to each school. School personnel were encouraged to contact the Clinic specialists regarding problems or concerns; however, the reading specialist found that the contact regarding the student was nearly always initiated by the Clinic personnel.

During a Clinic staff meeting, the specialists tried to develop plans for more efficient operating procedures within the Clinic. The case conferences held two afternoons a week, one on Tuesdays for the purpose of intake and another on Wednesdays for the purpose of discharge, were too time consuming. As a result, the psychologist and reading specialist proposed the following changes at a staff meeting with the specialists.

Psychologist:

> So for the last two weeks we've combined the intake and discharge into one meeting each week. And, this sounds a bit bizarre, I suppose a bit gross, but in order to keep everybody moving along, the diagnostic teacher has a timer and she gives us ten minutes each to report on each of the four kids and it is working out a lot better. (5.7.81)

The decision to combine the intake and discharge meetings gave the specialists an opportunity to engage in more follow-up activities. Extra time was also needed for phone calls, home visits, reports and liaison with outside agencies. During the Clinic case conference which was now to be held each Wednesday afternoon, specialists would not be allowed to step out of the meeting to answer phone calls. Apparently, there were many interruptions due to this problem which caused frustration and an unnecessary waste of time. A new rule emphasized that each specialist as well as the diagnostic teacher were to attend all meetings on time.

A suggestion was made with regard to the role of the case coordinator. In the past, the case coordinator handled intake of referrals from field specialists who were assigned to particular teams. Dissatisfaction was expressed with this operating procedure as there was a concern that particular specialists carried a heavier work load. The reading specialist suggested that there was a need for alternate plans to enable duties to be carried out in a purposeful and efficient manner.

Reading Specialist:

> We are looking at the case coordinator and how that person might be designated. In the past, we've been working on this model, the case coordinator has been firmly aligned with certain field teams. So actually, it was my husband that suggested, why don't the case coordinators be assigned every fourth case and I weighed that in my mind for a long time before suggesting it to anyone and it seems to be sensible. And interestingly, the social worker tallied up the number of cases we've all handled and they aren't that disproportionate but at one point, I felt they were really disproportionate to me because they just seemed to be really really coming. (5.8.81)

In a team meeting with the Director of Childhood Services, the psychologist presented a written proposal regarding the organizational changes proposed for the Clinic. The reading specialist indicated that the changes were essential as she believed that it was impossible to follow-up on diagnostic teaching suggestions within the current structure of the organization. The Director pointed out that noon-hour conferences were interfering with assessment time as the staff had to leave the Clinic at 11:00 a.m. to travel to schools. He questioned whether it was practical to have noon-hour conferences at the school:

> Reading Specialist:
>
> The reason is that after school conferences are really unpopular with the school staff.
>
> Director:
>
> They think their day ends at 3:30 do they? It seems a bit dumb that we have to shut everything down here at eleven o'clock to suit the convenience of the schools. It seems to me that they either make some arrangement to break the significant teacher from the school during some working hours, or sit down at half past three to do some extra work. If you have to work three nights a week or five nights a week nobody–
>
> Reading Specialist:
>
> I'd be pleased to work two nights a week.
>
> Director:
>
> Nobody asks you to do it, that's...... Prepare some recommendations for next year. You've outlined a number of options and I think we should spend really a half day on plans for next year. Now if you prefer to set this aside for now and come back later and talk about it point by point. The only real concern that I have is..... numbers. It's difficult to assure funding when the impact of the program is limited to relatively few children. (5.13.81)

The Director asked the clinical specialists and the diagnostic teacher to document activities as he reported that the School Board was trying to make the schools responsible for specialized programming. He suggested that the increase in time allocated for assessment and clerical work would limit the number of referrals which could be processed. The Director closed the discussion on this topic by stating "every time we change the bloody system, it takes the personnel three years to learn it."

Interpretation

Steers (1977) indicated that organizations must coordinate activities in a logical predictable fachion in order to transform inputs (client referrals) to outputs (services rendered). The personnel at the Diagnostic Clinic recognized there was limited time for clerical work as well as follow-up, a finding supported by the research of Jacobs (1978) and Ulman (1979). Clinic personnel also recognized that the structure within the organization required reorganization in order to enhance the effectiveness of the service delivery system. The findings in this chapter would therefore support Freeman (1973) who suggested that environmental pressures tend to increase formalization and general tightening of the organization.

Summary

This chapter has been presented to provide knowledge related to the background and operating procedures of the Diagnostic Clinic. A job description of each of the clinical specialists and diagnostic teacher has been presented to provide information regarding the roles and responsibilities of the staff. Organizational problems related to time constraints, scheduling of case conferences and report writing were discovered. In order to address these difficulties, the clinical specialists and their superior made plans for organizational change. A brief interpretation of the data has been included in the chapter.

Chapter 5

FINDINGS

Interviews with ten field specialists, ten principals, ten teachers and ten counselors were conducted. Based on the interview data, 949 comments related to the interorganizational relationships between the Clinic and schools were classified. Categories associated with the establishment of relationships included: need for the Clinic's support, capacity of the Clinic to handle referrals, goals and service of the Clinic, agreement on outcomes and the clinical specialists' expertise. The following categories were associated with the liaison system established between Clinic and schools: nature of communication, coordination of service, roles and responsibilities and decision making. These categories as well as the effectiveness of the service delivery system will be discussed. Findings based on the four case studies will also be presented.

Establishment of Relationships

In order to establish a relationship with the Clinic, the school must have: (1) need for the service beyond resources available in the school. The Clinic must also have (2) the capacity to serve the school and personnel at the school must have (3) knowledge of the Clinic's service. The (4) agreement regarding recommendations is reflected in the objectives and outcomes of the referral. The (5) necessity of requesting service from the Clinic has been related to the resources available within the school. The percentage of comments in each of these categories has been calculated.

Need for the Clinic's Service

On the basis of interview results, a total of 9 percent of the total number of comments made by respondents indicated a need for the service of the Clinic. The respondents indicated that services of the Diagnostic Clinic were required primarily for an indepth analysis of students and for the purpose of program planning. The Clinic provided an opportunity to have the child assessed in a different learning environment or small group setting. Respondents indicated that the Clinic was needed to "alleviate anxieties" of parents and teachers who had problems coping with the child. Comments also indicated that the Clinic could act as a "buffer zone" when problems existed between school personnel and parents. The Clinic was described as a support system for teachers when all other alternatives had been exhausted.

Sample Comments:

> The students that are usually referred to the Clinic are children that we see as needing more assessment time or more indepth assessment time than can be offered within the Bureau time table. The appropriate Clinic referrals are the more difficult or puzzling types of cases.
>
> I feel there's a real need for that service. With the number of children we find that we are frustrated in knowing what to do with the kids. We've reached the end of the kinds of services that are normally available and we feel that we need additional assessment to help us with planning proper programming and in handling kids like some of those that we've sent to the Clinic.
>
> I wanted to know what I could do further because I had sort of exhausted all the ideas I had.

Capacity of the Clinic to Handle Service

A total of 14 percent of the total number of comments made by respondents focused on the Diagnostic Clinic's capacity to handle client referrals. Within this category, only 16 percent of the comments indicated that the Clinic should not be expanded, while the remaining 84 percent of the comments suggested that an expansion of service would be desirable. Respondents were dissatisfied with the "wait-list" for assessment as well as lack of personnel for follow-up and on-going programming. The most common suggestion was to establish a second Clinic. The recommendation was made that the Clinic staff allocate more time to observing children in the regular school classroom and provide in-service for teachers. Additional suggestions included the need for an occupational therapist on the Clinic staff and extra teacher aide time. It was proposed that funding be obtained for substitute teachers allowing school personnel release time to visit the Clinic.

Sample Comments:

> We've been fortunate that the referrals that we've had have been handled fairly quickly but I think in some cases there are children who wait for quite a long time before they can be assessed and if there were probably more facilities available, then more of these children could be helped earlier.
>
> I went to visit the Clinic and that was because I made internal arrangements that I had the opportunity to spend half a day at the Clinic. If I hadn't been able

> to make internal arrangements, I wouldn't have been able to even get over and so I think maybe somehow where they would supply a sub for half a day because at another time I might not be able to have that privilege.
>
> I am not sure whether they have access to occupational therapists, for one thing, and sometimes I think that might be an additional service that would be helpful or useful. And I don't necessarily mean with all children but sometimes with some children it's a useful – I know that sometimes that service is available outside but very difficult to get at.

Knowledge of the Clinic's Service

Of the total number of comments, 10 percent indicated that the school personnel were aware of the service obtained from the Clinic; however, new teachers were not as familiar with the goals or the service. A concern in this area focused on the student's adjustment to being removed from the regular classroom for the assessment at the Clinic. Goals of the Clinic's service were identified as providing liaison between the home and school, assessing the student's academic and emotional problems, conducting speech/language assessments, observing student behavior, providing program plans and referring to outside agencies for follow-up.

Sample Comments:

> Now I believe the mandate says that they look at the child in an in-depth manner for a restricted period of time and after that it is turned back over to the school and the field team for that particular area and the Bureau team then does more follow-up.
>
> They've tried to act as a liaison between the home and the school to help us and assist us in providing the services that we can to help the child.
>
> I would say basically that we would be looking for a more indepth analysis than we can provide for a student within the resources we have in the school. For example, look at the child not just in one area or areas separately, but what they will do is do a total analysis plus they will actually try out different suggestions and watch how the child reacts so we get an overall, indepth analysis.

Agreement on the Clinic's Recommendations

Only 5 percent of the total number of comments made by respondents focused on the outcomes or recommendations made by the Clinic. Within this category, 44 percent of the comments indicated agreement with the recommendations of the Clinic's suggestions while 56 percent indicated dissatisfaction with the Clinic's recommendations. Positive comments focused on the manner in which respondents were consulted and the usefulness of the recommendations while negative comments indicated that the Clinic personnel provided a great deal of advice and assistance but asked for very little input from the classroom teacher. In these cases, the Clinic's recommendations were not found practical for implementation in the student's regular classroom setting.

Sample Comments:

> I think that they're trying to do it in as efficient a manner as they can and I think decisions are made within that framework that are sometimes expedient to the professionals involved but are not always the best for the school.
>
> There were not practical suggestions or helpful suggestions that could actually be recommended to the teacher. Also, at the consultation, it was noticed that there was a great deal of discrepancy and inconsistency on what the various consultants were reporting. I found I was getting very, very upset.
>
> I mean we had good suggestions that worked well now that the child is in adaptation which was one of the things that was recommended. And I think the approaches that they suggested to the adaptation teacher have been implemented in the classroom and seem to work very well and even the homeroom teachers have said that the suggestions that were made at the conference that have been implemented within the regular classroom have really been effective.

The Clinic's Expertise

Concerning the Clinic's expertise, 6 percent of the overall comments focused on the professional skills and competencies of the specialists and school personnel. Field specialists and clinical specialists were found to have the most comparable skills and abilities. Field specialists had similar training and expertise, however, the time constraints of the field placement prevented in-depth assessment, observation and programming. Several counselors who were interviewed were trained psychologists, however the need for assistance from the clinical specialists was based upon skills of the interdisciplinary team who were able to observe and test the student over an extended period of time outside of the school. Because of training and background experience, principals and teachers turned to counselors and specialists and the Clinic to provide assistance for students with complex problems.

Sample Comments:

> Well my role as a field specialist is similar in that I'm doing the same type of assessments. The roles are very similar. The difference is that a specialist working in the Clinic has more observation time.
>
> With the Diagnostic Clinic staff, I think one of the main differences is that they get to work with the child on a one-to-one basis over a period of time

> and they become more familiar with the kinds of problems that we experience in the classroom dealing with these kids. With the field people and often with the school counselor too, they don't get to see the child in the same way and it's often more of a one-shot kind of assessment that's done.
>
> As a teacher, I would comment that if the Clinic staff is able to have case conferences and testing in the afternoons, I would comment that I can't find time to make one phone call to a parent and you get a little - you begin to realize how different your experiences are.

Liaison Between the Clinic and Schools

The following categories have been based on the liaison system established between the Clinic and schools. The (6) nature of communication between the Clinic and school has been associated with delivery of clinical services. The (7) coordination of service has been analyzed through the referral procedure, the case conference, the written report and follow-up. Additional categories related to liaison between the Clinic and schools included (8) concerns regarding roles and responsibilities of clinical specialists as well as (9) decision making shared between the Clinic and schools. Each of these categories will be described.

Nature of Communication

A total of 10 percent of the comments made by respondents have focused on the nature of communication between the Clinic and schools. Within this category, 52 percent of the comments were positive with regard to communication and contact received from the Clinic. Comparatively, 48 percent of the comments within the category indicated that school personnel and field specialists desired more contact in the form of face-to-face interaction, case conferences, phone calls and follow-up. Time constraints related to the job were mentioned as a cause related to communication difficulties. Responses indicated that communication should be a two-way process with schools initiating more contact with Clinic personnel.

Sample Comments:

> If the teacher has further questions I suppose she can always phone back to the specialist involved but that's not necessarily done.
>
> The most contact I have, fairly good contact with the psychologist, she calls about once a week to keep me informed on - even though the child has left the Clinic - her relation or contact with the parents or anything that has come

> up so she's kept me very much up to date on what's happening so I appreciate that.
>
> But I know that once the student is in there, other than what the teacher might feed back to me from her visit, then I hear nothing from them until the case conference.

Coordination of Service

A total of 19 percent of the comments made by respondents focused on the coordination of service between the Diagnostic Clinic and schools. Within this category, 13 percent of the comments were related to the referral procedure, 29 percent of the comments were associated with the case conference, 24 percent of the comments concerned the written report and 34 percent of the comments were based on the follow-up conducted by the Clinic. In order to fully describe the coordination system as perceived by respondents each of the specified methods used for coordination of service between the Clinic and schools will be discussed.

Referral Procedure. A total of 13 percent of the comments relating to the coordination of service focused on the referral procedure. Within this category, 61 percent of the comments indicated that respondents were satisfied with the way in which referrals were screened by field specialists. However, 39 percent of the comments indicated displeasure with the referral system. Negative comments were related to frustration regarding the "wait-list" for intake to the Clinic. Respondents indicated that more field specialists were required to screen as well as process more of the cases. Mention was made of the fact that different field specialists had different criteria for activating a Clinic referral. In general, respondents did not feel that the Clinic had the capacity to accept referrals directly from the school although one of the respondents did want this privilege

Sample Comments:

> I think the referral procedure has worked probably well as far as our school is concerned. With the excellent counselor that we have on staff, he's able to provide us with a lot of the background information that's required, assist the teacher and when those measures have failed then the referral has gone to the field people and in cases where there was a real need for the Clinic assessment, then the child was referred.
>
> One would be that we go through the field teams and different field teams have different standards or criteria whether or not a child should go to the Clinic. So a child can go from one school that maybe isn't as serious a

problem as in another school.

> It seems to me a logical setup. Like for my little boy, he went through the counselor in the school and the field team tested him and then they recommended the Clinic. Yes, it seemed to work out fine for me.

Case Conferences. A total of 29 percent of the comments by all respondents focused on the case conference. Within this category 53 percent of the comments were positive and 47 percent of the comments were negative. Many comments indicated satisfaction with the nature of interaction between specialists and school personnel in the conference. The fact that the child was allowed back to the school at least three weeks before having the conference was mentioned as a concern. Some respondents stated that they felt the parents should be involved in the school conference rather than having a separate interpretation of test results. Other respondents revealed that parents are often confused by the "jargon." Teachers, in particular, stated that the case conferences were "hurried" as they were held during the lunch break at the school. Some of the information was noted as being "repetitious."

Sample Comments:

> We have found the case conference to be most positive. Generally the people who have been involved in a particular aspect of the assessment are the ones that have come out to the school and discussed their findings and recommendations with both the administration and counselling in the school as well as the teachers.

> Well we had the meeting with the social worker and the psychologist, the school principal and myself, the four of us met. For me there was a lot of – it was like sort of an overview. There was repetition because I had fairly good contact with the psychologist and when I went to visit the Clinic.

> O.K. I know in the past that I've been quite pleased with case conferences. Sometimes I feel that we overwhelm parents but sometimes that's what we want to do as well. They have sent out – whoever has been involved has a report to make. I like the idea that they typically meet with the school first and then with the parents so that we don't have surprises in the parent interview.

Written Reports. A total of 24 percent of comments made by respondents were associated with the written report. Of these comments, 52 percent were positive and 48 percent were negative. The positive comments focused on the comprehensive nature of the written document while the negative comments criticized the report for its length and "jargon." As well, respondents indicated that a summary or overview would be helpful for both teachers and parents. It was suggested that more emphasis be placed on well developed recommendations which could be implemented in the regular classroom.

Respondents also recommended that the reports be distributed to school personnel before the final school conference to familiarize participants with background related to the case.

Sample Comments:

> The written report provides us with the information in writing and often when you discuss things, there are points that you miss, things that you overlook or tend to forget and by having the written reports here, it provides us with something to go back to. It also is good for the teacher in that they can go back and look a the recommendations for dealing with the particular child in the classroom. And it's also there for a teacher to use the following year.
>
> I was presented with a twenty or thirty page report on this child that had information that could have been summarized in a paragraph or so. It didn't relate in many ways to what my concerns were at all.
>
> Well the written report. I mentioned it a little bit but I'd make it more brief maybe, more concise, less jargon as I said, and much more meaningful for the school and the parents.

Follow-up. A total of 34 percent of the comments made by respondents focused on follow-up of the clinical assessment. Within this category, 39 percent of the comments were positive and 61 percent were negative. Some of the respondents were impressed with the materials, teaching strategies presented in the report and liaison with outside agencies. The negative comments revealed that more emphasis should be placed on working with the student through specialized programming. Follow-up was required to consult both student and teacher in the large group setting or to provide an alternative placement for the student. Respondents indicated that follow-up home visits and consultation with the family were useful.

Sample Comments:

> I think probably the thing that I would like to see coming out of the Clinic would be more follow-up with the child in a more controlled setting, like a smaller setting where your teachers are trained and the staff from the Diagnostic Clinic can do some follow-up prior to sending him back to the classroom that they came from.
>
> We have found the follow-up to the assessments excellent. The people have followed up by home visits and they've also come back to the school and followed up on recommendations. In one instance where a recommendation involved a volunteer, there was follow-up and that was by the Clinic people and the volunteer was provided.
>
> I think the only way the Diagnostic Clinic will improve and satisfy the needs of the school is if they follow up the cases, come back to the classroom teacher, recommend procedures that she can use for this particular child.

Roles and Responsibilities

A total of 5 percent of the comments made by respondents indicated a concern regarding the differentiated roles and responsibilities of school personnel and clinical specialists. Problems were indicated as classroom teachers stated that clinical specialists were unaware of the tasks and demands of the regular classroom teacher. Because the clinical specialists observed and assessed a limited number of students in a small group setting. Teachers and principals indicated that the Clinic specialists developed unrealistic expectations which were reflected in the recommendations. Due to the large number of students assigned to the regular classroom teacher, the individualized program suggestions obtained from the Clinic were sometimes found impractical.

Sample Comments:

> The teachers are dealing with large classroom sizes and a number of kids, any small group of them behavioral problems or the same types of things as opposed to the consultant staff that are working with one child and devoting all their attention to it and it sort of creates a polar between the two different groups of people.
>
> At the present time I don't feel that the consultants of the Diagnostic Clinic meet the needs of the teachers in terms of they don't provide enough practical suggestions as to what to do with this child in terms of helping him integrate back into the regular classroom situation as well as helping to set up particular programs that not only meet the needs of the child but cater to the needs of twenty-five, twenty-six, twenty-seven other children in the classroom.
>
> Because of the indepth analysis they do, they can't take very many children and so very often you have to book months ahead and there's only a limited number of children that can be put through so to speak or have the services made available to them.

Decision Making

Only 1 percent of the total comments made by respondents focused on decision making between the Diagnostic Clinic and schools. Although the principal has ultimate authority with regard to responsibility for the student, the fact that the principal must sign the referral form indicated that decisions regarding the student should be made in consultation with the Clinic staff. Lack of concern regarding mutual decision making was indicated. In the forty interviews conducted with school personnel, only five comments were made with respect to decision making. These comments may also be associated with the fact that field specialists could become more involved in decision-making and the subsequent follow-up or recommendations.

> Sample Comments:
>
> With regards to the recommendations made by the Clinic, we (the principal and teacher) were definitely involved particularly by the input that we made initially when the referral was first made and there were discussions with the school personnel as to how we felt things should go.
>
> Usually our referrals are made through our guidance counselor in the school and if she feels that there is a particular need to go beyond say our sector team for help, then these referrals are passed on to the Clinic and so it's not my (principal) personal decision most of the time, it's based on the decision of the guidance counselor plus that of the teacher.
>
> But, with that extra information, you have a better idea of making, I think, you know, wiser decisions on the student.

Effectiveness

The general comments concerning the effectiveness, productivity and commitment of the Diagnostic Clinic have been classified according to the positive and negative concerns regarding the service delivery system. Of the total number of comments, 16 percent were positive while only 4 percent were negative. Samples of both positive and negative comments are presented.

> I feel that what they have to offer is of great benefit and it would really be a loss if they were to close down.
>
> We found the people to be top-notch people. The kinds of assessments that they have done have been excellent.
>
> I think that they have some very efficient people over there and I think that, as usual, the Oak View Public is getting more than their money's worth from those individuals.
>
> The only negative side effect that we run into sometimes is the time constraint and the waiting list.
>
> You're not really looking at a really long-term kind of commitment.

Findings Based on the Four Case Studies

Based on the reactions of the teachers, principals and parents of each of the four case studies, the following data was obtained. (1) A need for the service of the Clinic was indicated. (2) Respondents suggested that the service of the clinic be expanded to include another center. (3) School personnel were aware of the Clinic's goals and agreed with the objectives for the Clinic referrals. (4) It was suggested that brochures could be distributed about the Clinic at the beginning of each school term to help publicize the service, particularly for the benefit of newly hired personnel. (5) A problem was identified with respect to the coordination system due to the long wait for pupil assessment. (6) It was suggested that parents would benefit from a simple interpretation of assessment results which included a written summary of findings. (7) The "jargon" used in interpretation of test results to parents was noted as being confusing. (8) The overall effectiveness of the clinical service delivery system was perceived as positive.

Summary

Respondents indicated a need for the service of the Clinic and an expansion of the Clinic's service was suggested. School personnel and field specialists were aware of the Clinic's goals and service; however, new teachers required more information regarding special services. Respondents indicated that the Clinic provided advice and assistance; however, more consultation with classroom teachers was recommended. The referral procedure was perceived as satisfactory but the conferences were stated as being "hurried" with concerns regarding parent involvement. The written reports were noted as being too long and more emphasis on follow-up was suggested. Lack of concern regarding mutual decision making was evident between school and Clinic staff. The overall impact of the Diagnostic Clinic's service delivery system was considered positive by respondents. Findings will be discussed in the following chapter.

Chapter 6

DISCUSSION

The categories which have been discussed will be related to Van De Ven and Ferry's (1980) model on the formation and maintenance of interorganizational relationships. The major problem in this study has been to describe the interorganizational relations which existed between the Diagnostic Clinic and schools. In this chapter, the sub-problems concerning the situational, structural and effectiveness dimensions concerning the development of interorganizational relationships will be presented. The situational dimensions will be related to data regarding the establishment of relations between the Clinic and schools. Structural dimensions will be related to the coordination of the service delivery system. The effectiveness of the Clinic's service delivery system will be discussed.

Situational Dimensions

All organizations depend upon their environments or other organizations for information, clients or resources to maintain their objectives. Aiken and Hage (1968), Evan (1965) and Litwak and Hylton (1962) discussed the issues of interorganizational interdependence which may be related to the relationship established between the Diagnostic Clinic and schools. In a resource dependence model proposed by Van De Ven and Ferry (1980;310), (1) resource dependence or need for extra assistance is a necessary but not sufficient condition for establishment of interagency liaison. Other dimensions which may be considered include the organization's (2) ability to respond to problems and an organization's (3) awareness of other services available. In addition, (4) consensus refers to the terms upon which organizations agree to exchange resources. Finally, (5) domain similarity is a qualitative factor for explaining why organizations will become involved in a relationship. Following is a discussion of the subproblems related to the situational dimensions of the interorganizational relationships between the Clinic and schools.

Sub-problem 1: Resource Dependence

Do school personnel perceive a need for the services provided by the Diagnostic Clinic? Resource dependence has been defined by Van De Ven and Ferry (1981:321) as "the extent to which an organization needs external resources to attain its self interest goals for a specified period of time." On the basis of interview results, a total of 9 percent of the number of comments made by school personnel indicated a need for the service of the Clinic when resources within the school and assistance from field teams were exhausted.

Sub-problem 2: Response to Problems

What are the problems and possible solutions related to the Diagnostic Clinic's capacity to handle referrals? According to Van De Ven and Ferry (1980), the formation of an interorganizational relationship is based upon the organization's willingness to respond to problems. Although willing to respond to referrals, the Clinic had a long "wait-list"; therefore, it is possible that the school's willingness to refer students may be affected. The capacity of the Diagnostic Clinic to handle referrals was the third most frequent concern of respondents. Of the 14 percent of the total comments made during interviews, 84 percent indicated that the service of the Diagnostic Clinic should be expanded while 16 percent of comments indicated that the service should be maintained at its current capacity.

Sub-problem 3: Awareness

Are school personnel knowledgeable concerning the goals and services of the Diagnostic Clinic? Organizations must be aware of possible sources in other organizations in order to obtain needed resources. Tushman (1977) stated that boundary spanners are generally informed about the specific goals and resources in other organizations. In this study, field specialists were the boundary spanners who activated referrals from the schools to the Clinic. The field specialists were the most knowledgeable informants concerning the Clinic's service. School personnel were aware of the service; however, new teachers and parents required more information about the Clinic.

Sub-problem 4: Consensus

To what extent do school personnel and the Clinic staff agree with recommendations regarding referrals? Van De Ven and Ferry (1980:312) state that consensus refers to "the degree to which an organization's specific goals and services are agreed upon by the parties." If there is consensus regarding objectives, the greater the potential for interorganizational relationships to emerge. Consensus did not appear to be a major concern of respondents as only 5 percent of the interview comments were categorized in this area. Within this category, 44 percent of the comments indicated consensus regarding objectives and outcomes of the referrals while 56 percent of respondents indicated that the Clinic personnel provided a great deal of advice but did not request sufficient input from teachers regarding recommendations.

Sub problem 5: Domain Similarity

Can school personnel provide the same level of clinical service as that available through the Diagnostic Clinic? Van De Ven and Ferry (1980:308) state that domain similarity is the "sameness of agency goals, services and staff skills" in different organizations. When intermediate ranges of domain similarity appear, organizations may form a relationship to optimize joint resource usage. Counselors and field specialists were found to have similar training and background as that of clinical specialists. However, a total of 6 percent of the inteview comments indicated that the same level of clinical assessment conducted by the Clinic could not be provided within the school.

Structural Dimensions

The structural dimensions of an interorganizational relationship have been described by Van De Ven and Ferry (1980:301). 'Structures' are the arrangement and roles established to transact referrals between the Clinic and schools. Each of the following subproblems will focus on a structural dimension of an interorganizational relationship: (6) intensity, (7) formalization, (8) complexity and (9) centralizaion.

Sub-problem 6: Intensity

What is the school personnel's reaction concerning communication with the Clinic? Marrett (1971) has associated the intensity of a relationship between organizations to the information flow. Based on the number of referrals, specialists were required to communicate with approximately sixty schools. Considering the interview data, a total of 10 percent of the comments made by respondents focused on the nature of contacts received from Clinic personnel. Within this category, 52 percent of the comments were positive with regard to the communication between the Clinic and schools while 48 percent of the comments indicated that school personnel desired more contact with clinical specialists. It was concluded that communication should be a two-way process with a need for the schools to initiate more contact with the Clinic.

Sub-problem 7: Formalization

How are the referral procedure, case conference, final report and follow-up perceived by school personnel? Van De Ven and Ferry (1980:303) have defined formalization as the degree to which the coordination process, rules or procedures govern activities of organizations. The written referral procedure formalizes the agreement between the Clinic and schools. The case conference, final report and follow-up have been used as methods to transact referrals between the Clinic and schools. A total of 19 percent of the interview comments made by respondents focused on the manner in which the following techniques were used to coordinate service. Respondents made more comments in this category than in any other area indicating major concerns regarding strengths and weaknesses of the Clinic's coordination system.

Referral Procedure. Within this category, a total of 13 percent of comments were associated with the referral procedure. Negative comments were related to the "wait-list" for intake of clients. Respondents were generally satisfied with the method of using field specialists to screen referrals.

Case Conference. A total of 29 percent of the comments related to formalization focused on the case conference. Within this category, 53 percent of comments were positive and 47 percent of the comments were negative. There was a difference of opinion concerning the issue of involving parents in the final conference.

Written Report. A total of 24 percent of comments made within the category were associated with the written report. Of these comments, 52 percent were positive and 48 were negative. Concerns were expressed about the length of the report, the "jargon" and emphasis on diagnostic data.

Follow-up. A total of 34 percent of comments in this category focused on follow-up. Within this category, 39 percent of comments were positive while 61 were negative. More follow-up with respect to program planning was suggested.

Sub-problem 8: Complexity

What are the school's concerns regarding the roles and responsibilities of Clinic and school personnel? Relatively little concern was expressed in this area in relation to the number of comments classified in other categories. A total of 5 percent of the comments made by respondents indicated concern regarding the differentiated roles and responsibilities of school personnel and clinical specialists. Complexity has been referred to by Hall (1977) as different work groups, task specialities or different cliques who must integrate their efforts to coordinate services between organizations. Because the clinical specialists assessed and observed students within a small group setting, teachers and principals indicated that specialists developed unrealistic expectations for students. The teachers stated that Clinic recommendations were often too individualized for practical use within the regular class.

Sub-problem 9: Centralization

To what extent are school personnel and the Clinic staff involved in decision making? According to Van De Ven and Ferry (1980:304) centralization refers to the "locus of authority" with regard to decision making. School principals had responsibility for making decisions regarding students. Lack of concern regarding decision making was illustrated as only 1 percent of the comments were in this category. It is postulated that the category regarding consenus is related to decision-making. Consultation between the Clinic staff and school personnel was related to the Clinic's recommendations which were at times found impractical. More emphasis on decision making between the Clinic staff and school personnel may avoid such problems.

Effectiveness

Sub-problem 10: Perceived Effectiveness

Is the Diagnostic Clinic's service delivery considered effective by school personnel? Van De Ven and Ferry (1980:308) have defined effectiveness as the extent organizations "carry out commitments and believe relationships are worthwhile, productive and satisfying." Both positive and negative dimensions of effectiveness have been analyzed concerning the service delivery system between the Diagnostic Clinic and schools. In this study 16 percent of interview comments indicated that school personnel were satisfied with the service of the Clinic while 4 percent of comments expressed dissatisfaction with the service of the Clinic.

Inferences

Based on data presented in the case studies, the following inferences are postulated regarding the nature of clinical service delivery systems.

1. When difficult environmental influences such as difficult family situations and over-extended caseloads exist, a change in the design of the service system is required to enhance effectiveness.

2. When school personnel or parents are unwilling to take responsibility in carrying out proposed recommendations, the effectiveness of a clinical service delivery system is negligible.

3. The "jargon" used in the medical-professional orientation for delivering clinical services may adversely affect communication with parents and school personnel.

4. Emphasis on a diagnosis, report writing and conferences does not allow adequate time for follow-up.

5. Intentions and actions are examples of elements which may be conceived as loose couplings between organizations. There is little guarantee that recommendations (intentions) will result in their implementation (actions).

6. Evaluation of the outcomes related to the delivery of clinical services requires more attention by school personnel.

Based on data presented in both case studies as well as the semi-structured interviews, the following implications are related to the situational dimensions concerning formation of interorganizational relationships.

1. Clinical service delivery systems have been found useful for negotiating problem solving within schools as well as between the home and the school. Therefore, 'resource dependence' is a significant dimension in the interorganizational relationships which are established between psychoeducational assessment agencies and schools.

2. The ability of the clinical service delivery system to respond to problems may be affected by the number of personnel and resources available. Therefore, interorganizational relationships are not only affected by 'willingness to respond' to problems but also the capacity of the organizations to effectively handle tasks.

3. 'Awareness' of the clinical services which are available will determine whether organizations will engage in interorganizational relationships.

4. If clinical specialists and school personnel spend more time discussing appropriate recommendations, 'consensus' is more likely to occur between assessment centers and schools. Therefore, 'consensus' is directly related to communication which occurs between members in the interorganizational relationship.

5. Although the expertise of school personnel may be identical to professionals of an outside organization, the objective opinions of individuals outside the organization are often valuable. Therefore, 'domain similarity' does not hinder the establishment of

interorganizational relationships.

Implications concerning the structural dimensions of an interorganizational relationship are discussed below.

6. Communication must be viewed as a two-way process between organizations. THe more contacts between members of the different organizations the more effective the delivery system. However the 'intensity' of contacts or communication flow is affected by the number of tasks which must be conducted.

7. Although the 'formalized terms' of an interorganizational relationship may be acceptable to organizations within an interorganizational relationship, it is important to analyze the individual aspects of the liaison system for clues to effectiveness. For example, conferences are only as effective as the manner in which group processes within the conference are handled.

8. Different skills and training of personnel affect their perspectives in problem solving situations. Therefore, the 'complexity' of an interorganizational relationship is influenced by the nature of the organizations, the competencies of personnel and the manner in which skills are used to handle tasks.

9. Boundary spanners could become more involved in decision making to facilitate follow-up.

10. Effectiveness is not a separate dimension, but is related to the situational as well as the structural dimensions of an interorganizational relationship.

Summary

The individual categories which were most frequently mentioned were "formalization" and "effectiveness." The overall effectiveness of the service delivery system was perceived positively; however, improvements were suggested with regard to the methods used to coordinate service. "Resource dependence" and the school's "awareness" of the Clinic's goals were found to be essential for formation of the interorganizational relationships between the Clinic and schools. "Consensus" regarding outcomes may be improved with more "intensity" or communication between the Clinic staff and teachers, as recommendations were often described as impractical. Related to this problem, "centralization" or decision making between the Clinic staff and school personnel is an area which may require more consideration by school field specialists and Clinic personnel. Van De Ven and Ferry's (1980) model provided a useful framework for analyzing the service delivery system between the Clinic and schools.

Chapter 7

SUMMARY, CONCLUSION, IMPLICATIONS AND SUGGESTIONS FOR FURTHER RESEARCH

In conclusion, the final chapter will present a summary which will focus on the purpose of the study, the methodology, and findings. Inferences and conclusions related to interorganizational relationships and clinical service delivery will be presented. Finally, suggestions for further research will be outlined.

Purpose of the Study

The study was proposed to examine the nature of interoganizational relationships related to the Diagnostic Clinic's service delivery system. The study was designed to (1) observe the process of clinical service delivery system which existed between the Diagnostic Clinic and schools, (2) describe the nature of interorganizational relationships which developed and (3) determine the effectiveness of the clinical service delivery system. The research data were classified according to Van De Ven and Ferry's (1980) model concerning the formation and maintenance of interorganizational relationships.

Methodology

In this study, both qualitative and quantitative data were used. Considering the problems central in this study, a methodology was chosen which allowed direct observation of respondents. A social worker, psychologist, a speech pathologist and a reading specialist were observed as they delivered clinical services to the schools. During a two month period, the researcher accompanied the clinical specialists during their regular duties. Observations were made with respect to meetings and activities which occurred at the Clinic. Meetings and interviews were taped and transcribed.

Four case studies of client referrals were conducted. The impact of clinical service delivery was determined through contact with the parents, teacher and principal concerned with each of the four cases. Interviews were conducted three weeks after each pupil left the Diagnostic Clinic. Relevant documents were examined and a pupil file was compiled for each of the case studies. The Diagnostic Clinic's assessment report was added to each pupil file upon termination of case work. Other documents which outlined the operating procedures of the Clinic were also collected and analyzed.

Additional information concerning the Diagnostic Clinic's service delivery system was obtained through interviews with ten field specialists, ten principals, ten teachers and ten school counselors. A semi-structured interview and interview guide were used. Van De Ven and Ferry's (1980) model on the formation and maintenance of interorganizational relationships provided categories for classification of data. The researcher and an additional analyst classified data from the interviews and Scott's coefficient (Flanders, 1966:13) was used to establish inter-rater and intra-rater reliability.

Findings

Four case studies were conducted in order to document the reactions of school personnel and parents. Based on the reaction of the respondents, comments suggested that there was a need for the service of the Diagnostic Clinic and that the service should be expanded to avoid the "wait-list" for client referrals. In general, school personnel were aware of the goals and objectives of the service; however, new teachers and parents required more information regarding the services available. School personnel associated with the four cases were satisfied with the nature of communication between the Clinic and school. It was suggested that parents would benefit from a simple interpretation of assessment results which included a written summary of findings. The overall effectiveness of the service provided by the Clinic was perceived positively.

Interviews with forty respondents who referred clients to the Clinic were conducted. Findings based on the interview data have been related to Van De Ven and Ferry's (1980) model. Situational dimensions focused on (1) resource dependence, (2) capacity to respond to problems, (3) awareness, (4) consensus, and (5) domain similarity. Structural dimensions have been associated with (6) intensity, (7) formalization, (8) complexity and (9) centralization. The (10) effectiveness of the interorganizational relationship between the Clinic and schools has been determined.

Situational Dimensions

1. Resource Dependence. A total of 9 percent of comments made by respondents indicated a need for the service of the Clinic.

2. Response to Problems. In this general category, 14 percent of the total interview comments focused on the Clinic's capacity to handle service. Within the category, 84 percent of the comments indicated that the Clinic should be expanded while 16 percent of the comments did not believe an expansion of the Clinic's service was needed to adequately respond to problems.

3. Awareness. Of the total number of comments made in interviews, 10 percent indicated that school personnel were aware of the Clinic's service; however, new teachers required more information.

4. Consensus. Only 5 percent of the total number of comments were made in this category. Within the category, 44 percent of the comments indicated satisfaction with outcomes or recommendations while 56 percent of the comments indicated that a great deal of advice and assistance was given with lack of input from classroom teachers.

5. Domain Similarity. A total of 6 percent of the comments were related to the training and background of school personnel in comparison with specialists whose skills were required for indepth assessment of students.

Structural Dimensions

6. Intensity. In this category, 10 percent of the total comments made by respondents focused on the communication between the Clinic and schools. Within the category, 52 percent of the comments were positive with regard to contact received from the Clinic while the other 48 percent of the comments indicated that more contact with school personnel was desired.

7. Formalization. Considering the total number of comments made by respondents, 19 percent of the comments were made in this category. The referral procedure, case

conference, written report and follow-up were considered different aspects of formalization.

a. Referral Procedure. A total of 13 percent of the comments focused on the referral procedure; 61 percent of these comments indicated satisfaction with the process while 39 percent of the comments were negative. The "wait-list" for intake was mentioned as a problem.

b. Case Conference. In addition, 29 percent of the comments within this category focused on the case conference with 53 percent of these comments being positive and 47 percent of the comments being negative. Parent involvement was an issue and the conferences were described as hurried.

c. Written Report. As well, 24 percent of the comments in this category were associated with the written report with 52 percent of these comments being positive and 48 percent being negative. Respondents suggested shorter reports with less "jargon" and more emphasis on implementation of recommendations.

d. Follow-up. Of the comments made within this category, 34 percent focused on follow-up. Within the category, 39 percent of the comments suggested satisfaction in this area while 61 percent of the comments indicated that more follow-up was needed.

8. Complexity. A total of 5 percent of the comments made by respondents was concerned with the differentiated roles of specialists and teaching staff. Considering the different roles and responsibilities of Clinic staff and school personnel, comments indicated that specialists may have unrealistic expectations regarding recommendations which are practical within the classroom.

9. Centralization. Only 1 percent of the comments in this area focused on concerted decision making between organizations. This suggested lack of concern regarding mutual decision making from the perspectives of school personnel. Clinic and schools.

Effectiveness

10. Perceived Effectiveness. Considering the total number of comments made by respondents, 16 percent of the comments indicated that respondents were satisfied with the service of the Clinic while 4 percent of the comments indicated that respondents were dissatisfied with the service of the Clinic.

Inferences Based on Findings

Based on data presented in the case studies, the following inferences have emerged regarding the general nature of clinical service delivery systems. When environmental pressures produce negative effects, a change in the design of the clinical service delivery system is required. In delivering services between schools and assessment agencies, excessive use of "jargon" related to psychoeducational evaluation may adversely affect communication between specialists and parents as well as teachers. School personnel and parents must be involved in decision-making regarding client referrals as these individuals have the power and responsibility for implementing recommendations. The effectiveness of a clinical service delivery system will be negligible without the cooperation of these individuals.

A problem has been related to Weick's (1976) idea that intentions and actions are examples of loose couplings between organizations. There is currently little evidence to support the fact that recommendations (intention) will be carried out (action). More emphasis should be placed on follow-up in order to evaluate the outcomes of clinical service delivery systems. Restricting caseloads to provide adequate time for diagnosis as well as follow-up is essential to ensure that recommendations will be implemented.

The following are inferences related to the situational dimensions of Van De Ven and Ferry's (1980) model. These implications have also been related to the manner in which clinical services are delivered between schools and assessment agencies. An identified need for a service is required before assessment agencies and schools can become meaningfully involved in cooperative activities. The formation of a relationship between schools and assessment agencies is affected by the willingness of each organization to cooperate and to take responsibility for handling tasks which must be accomplished. When personnel in schools and assessment agencies have been found to have the same skills and abilities, it has not been viewed as a problem. Schools often desire the opinions of objective individuals who are removed from the school site.

Inferences have also been proposed regarding the structural dimensions of Van De Ven and Ferry's (1980) model. Communication must be viewed as a two-way process between schools and assessment agencies. As well, each aspect of the formal liaison system developed for delivering services must be studied for clues regarding effectiveness. For example, the referral procedure may be satisfactory; however, follow-up appears to be an area which must be improved. A relationship between schools and assessment agencies may be adversely affected due to the different competencies of specialists and teachers. Regarding the client, efforts must be made by personnel of assessment agencies and schools to understand each other's perspectives and integrate efforts in order to develop practical recommendations. More emphasis must be placed on decision-making between schools and assessment agencies.

Based on Van De Ven and Ferry's (1980) model, effectiveness appears to be related to the situational as well as structural dimensions of relations which develop between schools and assessment agencies. With regard to situational dimensions, a need for service, awareness of alternatives and cooperation between agencies with regard to a referral, are preconditions to successful coordination between organizations. If there is not a valid reason for interorganizational liaison and if there is not consensus regarding the goals of a requested service, the effectiveness of the coordination system will be affected. Likewise, the structural dimensions of interorganizational liaison can positively or negatively affect coordination of activities between assessment organizations and schools. As an example, misunderstandings can occur if communication between organizations is infrequent or unclear. Effectiveness may be related to several different dimensions of a coordination system.

Observations

Because the study was limited to the evaluation of a single service delivery system, it is not possible to develop generalizations. However, Van De Ven and Ferry (1980:308) presented several observations which may be discussed in relation to the findings.

> Observation 1. The greater the resource dependence the greater the interorganizational communication.

On the basis of findings, "resource dependence," need for assistance, caused school personnel to activate referrals to the Clinic. In cases of great urgency, extra telephone calls and meetings were arranged by principals and field specialists to obtain assistance. The staff of the Clinic were flexible in dealing with crisis cases and rescheduled cases on the "wait-list" when urgent situations occurred. In such cases, there appeared to be increased communication from personnel until the child was placed in the Clinic setting and Clinic personnel consequently initiated more contacts with the school after the assessment process began. The relationship between the need for service, "resource dependence" and "intensity" of communication, may therefore be supported.

> Observation 2. The greater the interorganizational communication the greater the awareness and consensus.

Findings in this study have indicated that school personnel required "awareness" of the Clinic's goals and service before a referral could be sent to the assessment organization. In some cases, there was not enough awareness with regard to clarifying the goals of the referral with school personnel. Concerning these client referrals, unclear or very general reasons for referral such as "home problems" or "poor school progress" were made. Therefore, the recommendations which resulted from the assessment were not always clearly linked to the expectations of the school staff. This problem negatively affected "consensus" between school personnel and clinical specialists. When teachers were consulted regarding recommendations, satisfaction was expressed; however, when teachers were not consulted regarding recommendations, suggestions were often found impractical. "Awareness" of goals, "intensity" of communication and "consensus" appear to be related.

> Observation 3. The intensity of an interorganizational relationship is a function of resource dependence, awareness and consensus.

The amount of communication between the Clinic and the schools was related to need for the service, the school's knowledge of the service and agreement on recommendations. However, the intensity of communication between the Clinic and the schools was hampered by time restraints, and a maximum caseload of approximately sixty referrals which could be processed each school term. Considering the number of client referrals which were processed, the Clinic's communication with the schools was as intense as could be expected.

> Observation 4. The greater the intensity of an interorganizational relationship, the greater the formalization.

In this study, organizational changes were proposed by the Clinic staff in order to provide more time for consultation phone calls and follow-up activities. Therefore, problems related to the "intensity" of communication had a direct effect on the "formalization" of the operating procedures in the Diagnostic Clinic.

> Observation 5. Centralization and complexity are also related to interorganizational communication.

"Centralization" has been associated with decision-making between the Clinic personnel and schools. Because principals had ultimate authority with regard to decision-making, consultation from the clinical specialists was designed to advise and assist the principal. The "complexity" of the roles of specialists from different disciplines affected decision making as school personnel, parents and specialists each have a tendency to view the child's difficulties from different perspectives. Attention must be given to carefully interpret each individual's perspective to ensure that decisions will be made and implemented in the best interest of the child.

> Obervation 6. The greater the effectiveness of an interorganizational relationship, the greater the interdependence and issue commitment.

The effectiveness of the clinic's service delivery was directly related to issue commitment between the Clinic and schools. Van De Ven and Ferry (1980) also indicated that interdependence may be associated with the effectiveness of an interorganizational relationship. The interdependence between the Clinic and schools may be more appropriately described through Weick's (1976) concept of loosely coupled systems. A loose coupling between organizations carried the connotation of impermanence and dissolvability which may be associated with the completion of casework regarding an individual client. The observation which may be more appropriately applied to the findings of this study may be restated as follows. The greater the "issue commitment" the greater the "effectiveness."

Use of Qualitative Data

A major purpose of using qualitative research has been to describe the nature of a clinical service delivery system based on the personal reactions of respondents. Proponents of qualitative research such as Glaser and Strauss (1967), McClintock et. al. (1979) and Scriven (1972) have indicated that the personal reactions of respondents may be used to provide understandings about individual behavior as well as organizational behavior. In order to obtain the personal reactions of respondents, participant observations, semi-structured interviews and document analysis have been found useful methods for gathering qualitative results. Calder (1980:401) states that "qualitative research findings reflect the imprecision and subjectivity of everyday life." It is on these subjective impressions that inferences, observation and conclusions have developed.

The collection of valid and reliable data depends to a large degree on the interpersonal interaction between the researcher and respondents. Lawler and Drexler (1980:539) have presented newly developed assumptions regarding qualitative research. The research must be familiar with the client's orientation and implicit theories of organization. The respondents must know a considerable amount about the researcher's purpose for conducting the study. The kinds of techniques used must be able to reflect knowledge of the research setting, culture and climate. The researcher needs the information and knowledge of respondents in order to develop conclusions. These assumptions may be readily applied to the manner in which this research was conducted.

Observations and conclusions can be reached about organizations, more specifically, clinical service delivery systems by studying an individual case. A challenge in the future will be to find new ways to integrate findings from both case studies and quantitative studies in order to realize the full potential of organizational assessment. In this regard, qualitative studies involving clinical service delivery systems may focus on the cumulative results of different research projects involving individual case studies. Using qualitative analysis, a longitudinal study focusing on the effects of clinical services may be considered.

After completing a research project of this nature, there are always concerns regarding the applicability of the data and its relationship to existing or emerging theories. Lawler, Nadler and Cammann (1980:617) emphasized that the accuracy or validity of qualitative techniques are not ensured by the research techniques but by the relationship of findings with models which already exist. The research in this study has been linked to an explicit organizational model. Without such a framework, it would have been difficult to focus clearly on data which appeared uninterpretable using current theory. It is the uninterpretable data which have been found most useful in proposing new perspectives.

Critique Of The Model

From a substantive viewpoint, Van De Ven and Ferry's (1980) model provided a unique contribution for examining the situational, structural and effectiveness dimensions of an interorganizational relationship. However, different perspectives of interorganizational coordination could not be assessed using the conceptual framework for this study. Other indicators which may provide information regarding the success of handling client referrals may include the value systems and beliefs of the stakeholders regarding the etiology of the clients problems. Use of the conceptual model has restricted exploration of these areas.

In addition, the semantic differences between the terminology used in organization theory as compared with the narrative and verbatim quotes obtained through participant observation created an awkward and restrictive method for presenting the data. The labels for categories which emerge from research data should be closely related to the experiences which have been described. Use of the preconceived categories based on Van de Ven and Ferry's model (1980) limited the extent to which new directions or dimensions may have been explored. Further research must focus on the data which appeared to be difficult to interpret using preconceived categories.

An Additional Dimension

In this research, the data which appeared to be uninterpretable and impossible to integrate, focused on the attitudes of respondents as they influenced the effectiveness of interorganizational relations. Findings in this study illustrated that different respondents are often not in agreement concerning observations. The degree of disagreement appeared to be the most critical data as it suggested strengths and weaknesses which existed in the service delivery system between a Clinic and schools. In order to obtain various opinions and attitudes regarding the research, it was essential that different techniques and different data sources were used as McClintock (1979) proposed. Qualitative studies have been useful for allowing analysis of behavioral and structural as well as attitudinal data. Different respondents were found to have different attitudes which have been related to the effectiveness dimensions of an interorganizational relationship.

A basic contention held by Andrews (1978), Mutema (1981) and Van De Ven and Ferry (1980) indicated that the effectiveness of a liaison system is related to various patterns of interorganizational linkage. For example, the effectiveness of a service delivery system may be related to formalization, intensity or consensus. However, it is postulated that effectiveness may also be related to client and employee characteristics. It may even be argued that effectiveness is more related to the attitudes of respondents than to patterns of linkage between organizations.

Tichy, Tushman and Frombrun (cited in Lawler, Nadler and Cammann, (1981:381) discuss "interactional methods" which focus on attributions related to decisions, communication and influences which may affect relations between organizations. In order to study this area, attributional theory as implemented in the research of King (1979) may be adapted to assess the underlying beliefs and attitudes of stakeholders involved in systems of liaison between organizations. The attitudinal dimensions which appear to have had an effect on the interorganizational relations observed during the interviews conducted in this study are listed below.

1. Lack of empathy for environmental influences affecting particular stakeholders involved in a coordination system.

2. Resentment regarding the characteristics or personality of a particular stakeholder involved in a corrdination of activities between organizations.

3. Personal bias regarding a particular issue or situation which affects the operation of a coordination system.

4. Lack of insight or understanding regarding the technological skills needed to resolve identified problems.

5. Insecurity regarding personal skills of particular stakeholders and a tendency to engage in superficial involvement to protect credibility.

6. Negative feelings toward consultation or engagement in cooperative activity between organizations.

7. Positive feelings of commitment, dedication and enthusiasm for involvement in cooperative activities.

8. Beliefs regarding either an autocratic or democratic approach as the most appropriate means of resolving problem issues.

Conclusion

On the basis of findings, future research in this area must focus on the underlying beliefs and attitudes of stakeholders concerning issues and potential problems involved in establishing liaison systems between organizations. Based on the findings in this study, the following assumptions may be studied through future research in the area of clinical service delivery.

1. Stakeholders have various perceptions and motives; therefore, clinical service delivery systems should develop mechanisms which are flexible enough to be altered to suit the needs of respondents and the complexities of particular situations.

2. It is the "psychological contract" which establishes issue commitment between organizations engaged in clinical service delivery. The stakeholder's attitudes which result in a "psychological contract" are related to the effectiveness of a clinical service delivery system.

3. Stakeholders can productively become involved in servce delivery systems on the basis of many differenct attitudes. The manner in which attitudes are acknowledged through communication and decision-making can facilitate or hinder the relations which develop between organizations.

4. Based on an assessment of interorganizational relationships, there is no single or correct system which can be designed for delivering clinical services as the attitudes of stakeholders can change from time to time and situation to situation.

Van De Ven and Ferry (1980) have provided a framework for assessing the strengths and weaknesses of interorganizational relationships. Based on findings related to situational and structural as well as effectiveness dimensions, criteria have been developed to assess the effectiveness of a clinical service delivery system (Appendix H). Clinical service delivery systems may be analyzed by focusing on situational dimensions (the preconditions for liaison), structural dimensions (the coordination system) and attitudinal dimensions (beliefs affecting communication and decision making). In addition, emphasis must be placed on realizing the goals developed for the basis of a cooperative activity. Each of these areas has an impact on the effectiveness of a clinical service delivery system.

Implications

Notwithstanding the limitations of the data base, the findings of this study have a number of tentative implications. Because of the qualitative nature of this research project, the observations which have been discussed warrant further research through quantitative measures in a variety of settings involving interorganizational coordination. The relationship between consensus and centralization requires further substantiation. Due to the interrelatedness of Van De Ven and Ferry's (1980) situational, structural and effectiveness dimensions, it is not unreasonable to suggest that variables such as formalization, intensity and consensus be isolated and studied.

Clinical service delivery systems are becoming increasingly involved with external organizations such as hospitals, drug abuse centers, private counselling firms and social service agencies. Due to current budget restrictions, there is currently pressure on administrators to be aware of the possible constraints involved in coordinating services. On the basis of this implication, administrators must adopt accountability systems to ensure that coordination procedures allow opportunities for adequate communication and mutual decision making between organizations.

Suggestions for Further Research

Several recommendations for further research have been identified as a result of this study.

1. A future study of a clinical service delivery system may be considered through use of an alternative methodology using attitudinal dimensions as they are related to Van De Ven and Ferry's (1980) model.

2. Further studies concerning interorganizational relationships could be conducted on other clinical settings in order to compare findings with the outcomes of this study.

3. Other studies using multi-method approaches could be conducted which focus on inter-agency coordination between teacher training institutes and schools, social service agencies and counselling firms or other government agencies and private sector institutions.

4. Studies may be conducted using other conceptual models to enrich knowledge in the area of interorganizational relationships.

5. Studies may be designed using a longitudinal approach to assess the long-term impact of a clinical service delivery system.

This study has been an exploratory attempt to use both qualitative and quantitative data to assess interorganizational coordination. In view of the current research, replications of this particular study using qualitative data may yield marginal additional findings. Overall, the findings of this study suggest that Van De Ven and Ferry's (1980) model can be a useful tool for the applied assessment of interorganizational relationships. Further research related to this model and parallel indices are needed.

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APPENDICES

APPENDIX A

THE FOUR CASE STUDIES

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A Synopsis of each of the clinical specialist's assessment findings will be presented regarding the four case studies. The purpose of this appendix is to provide background regarding casework conducted at the Clinic.

Bobby's Case

Bobby, a grade four student, was referred to the Diagnostic Clinic to determine whether physical or emotional causes were related to his health problems. He was absent from school a great deal and when he did attend, he often complained of headaches, stomach aches and other ailments. Liaison with Bobby's physician was requested by the counsellor. Bobby had excellent verbal ability but poor work habits in the classroom; therefore, behavior management suggestions were requested.

Social Work Assessment

During a home visit the social worker obtained background information related to the case. The father, age 32, was a welder who worked away from home a great deal, and the mother, age 31, was a homemaker and bookkeeper. The parents both had a problem with alcohol abuse; however, the mother had been able to manage her problem for the previous six years. Both parents dropped out of school in grade eight. Bobby had two brothers, Tom, age 4, who was being treated for a growth deficiency and Roy, age 3. Bobby was expected to help his mother give hormone injections to his brother Tom. In a case conference at the Clinic the social worker remarked:

> I was with Bobby yesterday and I thought he was a very pathetic child. He just looks pathetic. He is the kind of kid that after you've spent some time with him you'd like to go and cry your eyes out and that's my initial reaction to him. He's extremely needy. His favorite people are his dad and his brother, Roy. He gave three wishes . . . that he would never, ever want to got to school, and his second wish was money, and it wasn't that simple, it was, I don't know "a million trillion dollars" and then the third one wasI'm not sure how he said it, but it--oh, he wished there would just be mother, dad, and he left out Tom. It's very significant . . . we talked about Tom and his illness and the role he plays in it. (4.28.81)

Through medical reports and liaison with Bobby's physicians the social worker found that Bobby was hospitalized at the age of two with pneumonia. At age six, he was placed on ritalin to control hyperactivity. The Public Health physician examined Bobby in January, 1981 and found him healthy but in a follow-up examination in March, 1981, a paediatrician diagnosed Bobby as having an "attentional disorder and fine motor incoordination." As a result, medication was prescribed. The Social worker summarized her findings in the Diagnostic Clinic final report:

a. Bobby is expected to fill an adult role in the family for brief periods of time (then fit back into his child role when father returns).
b. Bobby is resentful of his brother Tom, who is receiving a lot of attention for illness.
c. Illness (and substance abuse) is used in the family as a way of coping with unpleasant experiences.
d. Bobby uses illness to avoid going to school.
e. Because he does not attend school consistently, he misses new work and falls behind. He realizes that he is not doing well and develops somatic complaints. The situtation is a vicious circle.
f. Both mother and teacher are caught up in the circle. They can't assess Bobby's physical condition and they give in (thus reinforcing the avoidance behavior). (5.27.81)

Psychological Assessment

A battery of psychologcial and personality tests was administered by the Clinic psychologist. The psychologist found that Bobby attained a full scale IQ of 114 on the Stanford Binet Intelligence Test. In addition, poor eye-hand coordination was detected although the psychologist indicated that this weakness was related to impulsiveness. Bobby's ability to remember visual material was better than his ability to remember oral instructions. When test results were reported at the Clinic case conference, the psychologist stated:

> He has a chronological age of 9 years 4 months and a mental age of 11 years 2 months. The Stanford Binet didn't detect any weaknesses. There were strengths in connection with general comprehension, vocabulary and verbal reasoning. In the memory area, there was a sharp contrast between the visual and the auditory, the visual being much stronger and he was extremely impulsive. (5.6.81)

The personality assessment completed by the psychologist indicated that Bobby appeared to be an insecure, anxious, impulsive and easily frustrated youngster. In the Diagnostic Clinic's final written report, the psychologist concluded:

> It is understood that, while his father is working out of town, Bobby is expected to assume an adult role in the household. This responsiblity produces anxiety, which interferes with his ability to concentrate on school work and provided Bobby with grounds for resentment at being told what to do at school. These behaviors make school difficult for Bobby and he responds by becoming sick. Being absent from school, and missing work, gives Bobby additional reason to be anxious. (5.27.81)

Reading Assessment

The results of the reading specialist's testing indicated that Bobby had good reading comprehension skills and although in grade four Bobby could read sight vocabulary words at the grade 6.9 level. During a Clinic case conference, the reading specialist reported her findings and in a conversation with the social worker, stated that she did not think Bobby should repeat his grade.

> Both orally and silently there's very good recall. Bobby's reading approach generally embodies omissions or insertions and when you look at them, they really don't confuse him, they're just little words. Sight vocabulary is superb up to grade five and that's a hundred percent. I gave him the Schonell Reading and he scored at the 6.9 grade level. (5.6.81)

On the basis of additional testing, the reading specialist determined that Bobby was able to spell at the grade 4.7 level. An analysis of Bobby's handwriting detected inconsistency of slant and stroke and a disproportionate use of letter size. The reading specialist concluded that Bobby could comprehend and read independently at a fifth grade level. He had a tendency to omit or insert small words but this did not seem to affect his reading comprehension.

Speech/Language Assessment

The speech clinician indicated that no articulation errors were detected during Bobby's speech/language assessment. Auditory acuity in the left ear was slightly below average. Concentration problems were related to his difficulty remembering oral instructions. Bobby scored well above his age level on a task where he had to complete verbal analogies. His understanding of grammar was above average; however, he sometimes made grammatical slips such as "I've rode in the car." The speech clinician suggested that Bobby expand his use and understanding of prepositional phrases.

On the referral form, the classroom teacher noted occasional immature speech. During a case conference at the Clinic, the speech clinician reacted to this comment and noted Bobby's preoccupation with his health:

> I haven't seen any of the immature speech that the teacher has referred to. Today when I asked him why he was away, there was a hesitancy or word finding difficulty. And the first thing he told me when he came into the room was "I have to suck this thing (cough drop) . . . because of my throat." (5.6.81)

The referral form stated that Bobby liked to contribute to discussions in the classroom but he seemed uninvolved as a listener. The speech clinician concluded that Bobby should paraphrase responses of students in the classroom to improve his involvement as a listener.

Recommendations of the Clinic

Specific recommendations were discussed at the school conference. The social worker stressed that Bobby should not be expected to fill an adult role as he worries about the family while he is at school and family counselling was suggested. With respect to his complaints of illness, the parents were asked to be firm in their expectation that Bobby attend school. The classroom teacher was told that Bobby's ailments were not an acceptable excuse for avoiding work. Emphasis was to be placed on improving Bobby's handwriting. Frequently scheduled parent/teacher contacts were suggested. Other specific recommendations were listed in the final report.

Interpretation

The effects of environmental factors as described by Hall (1977) have affected the service delivery system. Family and medical problems have been related to communication problems. In this case, linkages among the home, school and Clinic may be described through a medical-professional orientation. Nivens (1979) emphasized that health is often neglected in the team approach to remediation. Medical information concerning Bobby's case was not clearly related to the classroom teacher which caused frustration on her part. As well, a major recommendation of the Clinic indicated a need for more intense home-school communication. Barsh (1968) and Warren (1975) found that problems in psychoeducational evaluation result from different ways that parents, teachers and clinical specialists communicate with each other.

Billy's Case

Billy, a grade two student, was referred to the Diagnostic Clinic as his classroom performance was unsatisfactory. He had poor listening skills and problems understanding written material in class. The teacher wondered if emotional problems were related to his academic difficulties as he appeared somewhat withdrawn in the classroom.

Social Work Assessment

During a home visit, the social worker obtained the following information. Billy's mother was a secretary and the father was a construction worker. The parents had been separated for eighteen months. Billy lived with his grandparents during the week and stayed with his mother during the weekend. The mother planned to spend more time with Billy and indicated she would likely pick Billy up after work and take him home in the evenings. German was spoken in the grandparents' home. When Billy was upset he made faces or sulked in his bedroom but had difficulty verbally expressing his feelings. His hobbies included soccer and skating.

At a Clinic case conference concerning Billy, the social worker mentioned the possibility that the grandmother may be taking too much responsibility for Billy. The social worker stated: "He's babied by grandma, you know, and I think a lot is done for him so he doesn't need to do much for himself." The social worker planned to stress the importance of having Billy live with his mother on a permanent basis.

Details related to Billy's background were described in the social work report. He was hit by a van at age seven while riding his bike but there was no loss of consciousness and he didn't require hospitalization. Glasses were prescribed for Billy in order to correct a squint in the left eye. The social worker stated that Billy was a pleasant, compliant child who was sometimes picked on by other children. The social worker observed that Billy often made negative comments and appeared nervous. In the final report the social worker states:

> Billy is a very dependent child. His is immature and naive. He appears helpless and is sometimes picked on by peers. The mother will be encouraged to foster Billy's independence and build up his self-esteem. (5.25.81)

Psychological Assessment

The psychologist found that Billy was functioning in the average range of intelligence but weakness was indicated in ability to remember verbal instructions. As well, Billy had borderline ability to discriminate information which was presented to him in the written form. During a case conference at the Clinic, Billy's case was discussed.

> Psychologist: I finished by testing of him this morning but haven't had a chance to score some results. His mental age was eight, giving him an IQ of 93 . . . One of the first things I noticed about him was his sweating . . . Math was supposed to be one of his best subjects and he got a grade level rating of 2.9. (5.6.81)

The psychologist's assessment of Billy's personality indicated that Billy was an anxious and somewhat dependent boy. In the final report, the psychologist stated that Billy still worried about his father despite the fact that he had a close relationship with his grandfather. Mention was made of the difficulty level of Billy's work at school and the psychologist indicated that Billy felt good about attending the Diagnostic Clinic where his work could be geared to his level of competence. The psychologist concluded that it was easier for Billy to relate to other children in the small group at the Diagnostic Clinic and the withdrawing behavior evident at school was not apparent.

Reading Assessment

The reading specialist found that Billy was operating at a beginning grade two level in the area of reading. He was operating a year behind grade expectations despite the fact that he received resource room assistance in his school. Billy's listening comprehension was assessed and he was able to handle tasks at the beginning grade three level in this area. On a sentence dictation task, Billy did not know when to use capital letters. At a case conference, the reading specialist commented:

> When you look at his printing about half the letters sit a little bit below baseline. Not too much but it's noticeable. And when you look at his work generally, the lines don't come together. Just another interesting thing, although his sentences are not punctuated correctly, it doesn't get in the way of him reading the sentence in a meaningful way . . . . He's really tying in reading and writing. But still, everything I do, I look at him as a beginning grade two. (6.6.81)

Speech/Language Assessment

The speech clinician observed that Billy did not communicate readily and was too shy to ask for help. An audiometric test indicated that Billy had normal hearing and average ability to discriminate sounds; however, Billy had to compensate for a very limited ability to remember oral instructions. Regarding Billy's speech and oral language development, the speech clinician made the following observations in the Clinic's final report.

> Billy did not appear to make any articulation errors in his speech. Initially, his conversation was limited to mainly two or three-word sentence fragments. When he was more familiar with the Clinic and its personnel, Billy's conversation contained good statments which included some complexities, of adverbial phrases. (5.25.81)

The speech clinician found Billy's use of grammar irregular and immature for a student of his chronological age level. Difficulties were experienced when Billy was asked to identify initial or final consonants and medial vowels. As well, he had a problem sounding out multisyllabic words. The speech clinician found that Billy had no difficulty predicting the presence of "periods" in passages read aloud although he had difficulty punctuating written language passages. Billy had acquired a good vocabulary but rarely spoke or volunteered information in his classroom.

Recommendations of the Clinic

The Clinic staff recommended that Billy be placed in a special class for learning disabled children in the fall. The reading specialist made several specific recommendations in the language arts area stressing that any oral directions given to Billy should be broken into short simple units. When possible, Billy was to repeat the verbal instructions. The speech clinician recommended that Billy use sound blending to discriminate words and suggested that he learn common prefixes, suffixes and structural word endings. Other specific recommendations with regard to program planning were included in the final report.

Interpretation

An environmental factor, the student's home background, as well as the design of the service delivery system affected the relationship between the Clinic and the school. In this case, the Clinic's recommendations were not fully supported by Billy's grandmother who felt displaced when the Clinic recommended that Billy spend more time in the custody of his mother. Bronfenbrenner (1979), Ricci (1979) and Schorr and Moen (1979) have suggested that careful planning is required to ease the situation where one parent has custody of the child. In addition, the length of time required for the clinic to process the referral was a problem. The Clinic recommended that Billy be placed in a special education setting.

Tom's Case

Tom, a grade three student, was referred to the Clinic upon the mother's request as she suspected that her son may have mild learning disabilities. The mother was also concerned Tom may be asked to repeat his grade. Her comments in the intake conference were noted:

> They're saying that he's goint to fail. I had asked the teacher this year that if there were any problems, give me a call. Try and catch his problems early and the only indication I had of problems was before Christmas. They asked me if I would sign a homework book when he brings his homework home and just before a report card came out, the teacher called me to say he was going to fail. (4.21.81)

The teacher was concerned that Tom seldom completed his work in class.

Social Work Assessment

The mother visted the Clinic in order to give background information to the social worker. The mother, age 27, was a business representative for a dictaphone company and the father, age 30, was a mechanic. The parents were divorced and the father had not seen Tom for the past five years although he had visiting privileges. The maternal grandparents were very supportive to Tom and his mother. Tom had many babysitters and spent two years in Day Care before entering school. Tom's hobbies included cubs, swimming and he was assigned an Uncle at Large who did not visit on a regular basis.

The social worker recorded information related to Tom's health and development. Physically, Tom was healthy. Developmental milestones were normal with the exception of delayed speech and language development. In 1978, Tom was seen by a psychologist as he was often stubborn, upset and engaged in temper tantrums. At that time, he was referred for occupational therapy and and ritalin was administered on a trial basis for two weeks but discontinued. In 1980, he was referred to the Oak View Counselling Service for therapy as there was concern regarding fire setting, disruptive classroom behavior, inattentiveness and poor social skills. The school counselor had given Tom a great deal of attention and his behavior had improved on the past year.

The social worker indicated that the mother felt Tom's anger and frustration stemmed from his schoolwork. In the final report the social worker concluded:

> He will need a lot of encouragement to stay with tasks. He is reluctant to change his comfortable pattern of behavior, and may exhibit some anger if punshed. He is his own worst enemy in this struggle. He requires understanding and support to encourage him to change his attitude to work. He has made some gains over the past year and there is little doubt that he will continue to make progress. (5.20.81)

The social worker noted that Tom was pleasant and cooperative in the Clinic; however, he didn't complete the assigned tasks and had a tendency to give up when the work was difficult.

Psycholoical Assessment

The psychologist found that Tom was attention-seeking and related better with adults than with peers. She indicated that Tom preceived his maternal grandparents as an integral part of his family unit and he seemed to have resolved and accepted the long-term absence of his father. Although Tom exhibited attention-seeking behavior, he was far less demanding that the past records of his disruptive behavior indicated. In the final report, the psychologist discussed Tom's attention-seeking behavior:

> He did exhibit some attention-seeking behavior. For example, he made frequent trips to his teacher's desk on various pretexts. In addition, his social interaction with the other children was somewhat less than satisfactory due to his tendency to inform his teacher of their misdemeanors and to give them disapproving looks when they had transgressed. Nevertheless, although the other children did not tend to seek him out, Tom had no difficulty in finding someone to play with when he made the effort to approach and ask. On occasion, Tom became defensive and passively angry. This behavior was most pronounced when his teacher suggested an alternative way of doing something. (5.20.81)

Based on the Primary Mental Abilities Test, Tom's intellectual ability was average. Average performance was also diagnosed in the area of eye-hand coordination; however, the psychologist noticed that Tom had difficulty reversing letters. In a case conference at the clinic, the psychologist reported:

> I gave him the Primary Mental Abilities because he's been assessed so frequently with everything else. His deviation I see came out at 103, consistent with other testing. There were no areas of weakness. . . . I gave him the Harris. Directional confusion was indicated. . . . He's still doing a bit of reversing like 'p' comes out like 'b' and sometimes he mixes the order of letters in spelling. (5.14.81)

The psychologist concluded that Tom was not a learning disabled child and suggested that the mother may have inadvertently encouraged Tom's defeatiest attitude toward school.

Reading Assessment

The reading specialist found that Tom's oral expression was fluent as he used precise nouns and descriptive vocabulary. Tom was able to write the ideas which he expressed orally; however, his pencil grasp was poor, and he had trouble with cursive writing. He was able to spell at a grade 2.6 level. In a case conference, the reading specialist remarked:

> Well I found him very pleasant and cooperative. He is attending resource room. . . . He does read at home. . . . He's still printing most of his work in the classroom and that's fine with the teacher. They're being asked to write in spelling. He has had all the formal cursive instruction but his letters are not formed correctly. Everything sits on the line. . . .Spelling is 2.6 (5.6.81)

On the basis of additional tests administered by the reading specialist, Tom was found to comprehend material read silently better than orally. Instructionally, he was working at a appropriate level in terms of his grade placement as he was able to comprehend material at the grade three level. The reading specialist found that Tom was able to read silently without vocalizing passages while he read. Tom's comprehension was not hindered although he substituted and omitted small words while reading.

Speech/Language Assessment

Articulation problems were diagnosed by the speech clinician. Tom's upper teeth projected forward with a tendency toward an overbite occlusion. Consistent tongue protrusion between the teeth caused Tom to mispronounce the s/z sound. While Tom was at the Clinic, the speech clinician conducted speech therapy to work on the identified problem. In a case conference at the Clinic the speech clinician discussed this problem which may be related to protrusion of the teeth which required orthodontic work:

> It's one of those horrible little speech problems that take a lot of practice and a lot of patience and cooperation and interest on everybody's part and I feel that if we had orthodontic treatment with speech therapy it would help. . . .As far as speech therapy is concerned I would work with him from September to December. I would come out to see him at the school and that would have to involve some home practice. (6.4.81)

The speech language therapist conducted a hearing test and administered several tests to analyze Tom's language development. She found that there was no evidence of hearing impairment and Tom did not have difficulty remembering verbal instructions. Tom communicated easily and was verbally inquisitive. His grammatic understanding was average but mild memory or concentration lapses interfered minimally with his ability to follow directions. The speech clinician commented:

> His hearing was easily screened and indepth testing was also easily carried out. Bilaterally normal, between 0 and 10 Db. He was very talkative, very inquisitive and had lots of suggestions. (6.4.81)

Recommendations of the Clinic

The specialists agreed that Tom was not a learning disabled child. Tom's "on-task" behavior had improved, therefore a task-completion program was not recommended. The specialists concluded that Tom needed a great deal of emotional support and encouragement. More contact with peers and adult males was suggested to improve socialization skills and the lack of contact between Tom and his Uncle at Large was to be investigated. Suggestions were made to enhance development of skills in the area of language arts. Speech therapy was recommended for the fall term. The Clinic staff did not recommend that Tom repeat grade three.

Interpretation

The effectiveness of clinical service delivery is facilitated or hindered by the nature of interaction between the parents and school personnel. Bar-tal and Efraim (1979), King (1979) and Loven (1978) found that parents or teachers may attribute the cause of the problem to the other party. In Tom's case, the effectiveness of the service delivery system was undermined by factors related to the attitudes of both the mother and the classroom teacher. Tom's mother stated a need for more communication with the teacher regarding her child's academic difficulties but the teacher admitted that her dislike of Tom caused communication problems. Carlson and Hillman (1975) recommended that parents receive an explanation particularly when children obtain low grades.

Mike's Case

Mike, age 8, a child enrolled in a special education program for learning disabled children was referred to the Diagnostic Clinic as he was experiencing severe difficulty in the area of reading. A request was made for remedial suggestions.

Social Work Assessment

In an intake session with both parents, the social worker obtained the following background information. The father, 39, was a real estate agent and the mother, age 39, worked part time as a model. The parents had difficulty in school and both obtained a grade eight education. Mike had a sister, age 15, who repeated a grade and a brother, age 13, who had been enrolled in a special education class. Mike was described by his parents as a good looking, charming and cooperative boy. Since he has experienced school problems, he referred to himself as "retarded" and "dumb." Mike enjoyed bike riding, going to drive-in movies and visiting relatives with his family.

At birth, Mike required oxygen and was placed in the premature nursery for seven days due to aspiration pneumonia. At three weeks, Mike was returned to the hospital for espiratory distress and had at least three similar attacks the first year of his life. Mike walked at 14 months; however, speech and language development did not begin until 24 months. At age three, he was hospitalized with a broken collar bone. A Public Health examination was arranged on April, 1980 and neurological development was reported as normal.

Psychological Assessment

The psychologist administered the Wechsler Intelligence Scale for Children, revised edition, and obtained an IQ of 89. Results of testing indicated that Mike was functioning in low average range of mental ability. Severe learning difficulties were apparent in the area of arithmetic, reasoning, ability to remember verbal and visual cues and eye-hand coordination. Mike's understanding of word meanings, social judgements and general knowledge was average. During a conference with the parents, the psychologist reported:

> It really makes no difference whether you say at the low end of the average range or the top end of the low average range, but certainly well within normal limits and I think that's been shown by previous testing. What I have found is that he has memory problems and unfortunately they're both in the visual area and in what he hears and that's kind of a tough one. It means that it's very hard for him to compensate by relying on his ear to help him with his memory visually. (5.22.81)

Reading Assessment

The reading specialist found that Mike's oral language was precise exhibiting varied types of sentence structures; however, Mike was unable to verbally express ideas which he wanted to print. In attempting to print a sentence, Mike was unable to use capital letters and periods correctly. On a spelling test, Mike was found to be working at a .7 grade level as he experienced confusion in using short vowel sounds and had difficulty reversing letters such as 'p' for 'q' and 'n' for 'h'. Although Mike spent two years in grade one and a year in special education, he was still reading at a pre-primer level.

In the area of phonics, the reading specialist noted that Mike was able to sound out all consonants as well as vowels except the letter 'u'; however, he was unalbe to sound consonant blends. In the final report the reading specialist noted:

> Although displaying limited success, he experienced difficulty blending correctly identified sounds into a known word. He often tried the long vowel sound first, not then using the short vowel counterpart. His approach to reading was noticeably more relaxed and confident in contextual reading. (5.27.81)

Many remedial reading suggestions were proposed. Use of a language experience approach, sight vocabulary development as well as use of phonics in spelling and reading were general considerations. The reading specialist emphasized the importance of reading library books at home and encouraged Mike to reread stories which he had mastered.

Speech/Language Assessment

The speech clinician noted weakness in Mike's ability to remember verbal instructions. Comparing previous test results, Mike made "dramatic" auditory perceptual gains" in the past few years. Audiometric testing indicated that hearing was within normal limits; however, Mike did have difficulty recognizing input changes from one ear to another. Articulation was not a problem. The speech clinician stated that concentration on only remedial word attack and high interest low vocabulary books would jeopardize language development and a language experience approach was emphasized as a useful remedial technique.

The speech clinician concluded that Mike's ability to remember auditory stimuli was considerably below average and an attentional memory deficit affected his ability to make adequate academic progress. Observations which were made in the Clinic classroom indicated that Mike often appeared detached and disinterested. He seldom asked for assistance and required a great deal of encouragement to express ideas. In the final report, the speech clinician made the following suggestion:

> Science and social studies appeal to him and should provide incentive for him to use his verbal abilities to their fullest extent. It has been noted that sounding out loud is a word attack method that Mike avoids. Mike will need to rely upon context and other clues to compensate for his difficulty which surely stems from his limited memory span. (5.27.81)

Recommendations of the Clinic

After three years of formal education in the Public School System, Mike was still unable to read adequately at the grade one level. The Clinic staff recommended that Mike be transferred from the special education class to a private school for children with language and learning problems. Arrangements were made to have Mike transferred; however, the parents decided to move out of the city. Arrangements were made to have the assessment report and recommendations sent to the new school system.

Interpretation

Characteristics of clinical problem solving have been discussed by Elstein (1977) who distinquished two major types of clinical models; the diagnostic and the therapeutic. In all of the cases which have been outlined, emphasis has been placed on diagnosis. Although the clinicians have determined what action should be taken, provision for evaluation of the proposed recommentations is a weakness in the clinical service delivery system.

Summary

An overview of the casework of four students referred to the Diagnostic Clinic has been presented. The purpose of this section has been to provide background as the reactions ofthe principal, teacher and counselor involved in each of these cases have been described in the chapter entitled 'Findings'. The reasons for referring students to the Diagnostic Clinic, the assessment results and recommendations have been summarized. For each case, salient points noted in case conferences at the Clinic and schools have been described. The referral procedure, contact with the home, case conferences, the final report and follow-up have been identified as components of the clinical service delivery system.

APPENDIX B

SAMPLE ASSESSMENT REPORTS

DISCHARGE REPORT–DIAGNOSTIC CLINIC
CHILDHOOD SERVICES, OAK VIEW PUBLIC SCHOOLS

DATE: MAY 27, 1981

NAME: Bobby
BIRTHDATE: January 7, 1972
AGE: 9 years, 4 months
SCHOOL: Road Side
GRADE: Four
PARENTS: Pat and Bert
ADDRESS: 8942 - 12 Street
TELEPHONE: 642-9304

CLINIC ADMITTANCE: April 21, 1981
CLINIC DISCHARGE: May 8, 1981

CASE COORDINATOR: Reading Specialist

REASONS FOR REFERRAL:

1. Concern regarding the etiology of health problems – are these problems physical or emotional?

2. Inability to concentrate or complete tasks.

3. Excellent verbal skills and poor pencil/paper work.

4. Liaison with the Children's Hospital will be required.

5. Help with behavior management and a task-completion program for use in the regular classroom is requested.

MAJOR RECOMMENDATION:

Liaison between home and school be encouraged through:

1. a parent/teacher conference held in early September, 1981 to discuss:
    a. Bobby's medicinal needs, i.e., if he is on medication, what type, knowledge/observation of effects (both positive and negative), when adminstered;
    b. classroom performance and behavior expectations in conjunction with joint home/school approaches to support expectations;

2. frequent, scheduled parent/teacher contacts, e.g. weekly phone call, relating both positive and negative aspects.

NAME: Bobby DATE: May 13, 1981
DOB: January 7, 1972
ADMISSION: April 21, 1981

SOCIAL WORK ASSESSMENT

FAMILY CONSTELLATION:

The father, age 32, is a welder. He operates his own company on contract with Imperial Oil in Issugnak. He was born and raised in Saskatchewan. His parents, a brother and sister live there. Carl did not like school, dropped out in Grade 8 and was living on his own at age 15.

The mother, age 31, is a homemaker and bookkeeper for the company. She was born and raised in Saskatchewan. She is one three siblings, her father is deceased, her mother lives in Oak View. She found social studies difficult at school. She dropped out in Grade 8 because of a nervouse stomach. She worked as a waitress prior to her marriage.

Bobby is the student being assessed.

Tom, brother, age 5, does not attend kindergarten. He is being treated for a growth deficiency.

Roy, brother, age 3, is the youngest child.

DEVELOPMENTAL HISTORY:

Ann had a miscarriage prior to her pregnancy with Bobby. This pregnancy went well. Forceps were used in the delivery. Bobby was a healthy baby. He weighed 6 lb. 2 oz.

Milestones were achieved at the appropriate times. Bobby cut his first tooth at 6 months, spoke words at 9 months, walked at 11 months and was toilet trained at 24 months.

At 2 years, Bobby was hospitalized with pneumonia. He required oxygen and antibiotic treatment. He was found to be allergic to Penicillin. He was hospitalized twice with pneumonia in his 3rd year, and again with dehydration. Bobby has had mumps.

At age 6, Bobby was placed on Ritalin to control hyperactivity. The medication improved attention span and concentration. At age 7, he was examined by the public health physician, Dr. Brown. She found him healthy and neurologically intact. (EEG-normal Jan., 1981)

Dr. Black examined Bobby March 19, 1981. His diagnosis was attentional disorder and fine-motor incoordination. There was concern regarding the medication which initially had improved school performance. Bobby was placed on Mellaril for a 2 week trial. Sleep habits and appetitie improved but school performance remained the same. Ritalin was resumed at a reduced dosage.

Dr. White, Paediatrician, prescribed Pertofrane 25 mgm twice a day on April 6, 1981. Bobby slept better but continued to be very active during the day. Prior to Clinic admission Bobby suffered from nausea and rash. On April 21, his first day at Clinic, he experienced a motor seizure and muscle tremors. Dr. White regarded the seizure as a side effect ofthe Medication. He perscribed Tegretol 200 mgm (1/2 tablet twice a day) April 27th. Dr. White states that Bobby's physical difficulties are functional and should not limit his school attendance.

SOCIALIZATION:

Bobby is the eldest child in the family. He is a bright and active boy. He has been healthy except for attacks of pneumonia requiring hospitalization during his 2nd and 3rd years of life. Bobby's behavioral difficulties were identified when he began school. He was described as active, distractable and immature. These behaviors are still a problem for Bobby in the school setting.

Family dynamics paly a significant role in Bobby's difficulties. Father works out of the city for 2 weeks and returns to the family for 2 weeks. He has given Bobby clear messages that he should look after the family while he is gone. The mother seems to manage better when the father is home. When he is away, both the mother and Bobby develop somatic complaints of headache or stomach pain. Bobby often uses illness to avoid attending school.

Bobby is jealous of Tom as he has become the centre of interest. Tom has a growth defiency requiring injections of medication three times weekly. The mother administers the injections while Bobby holds Tom down.

Both parents had a problem with alcohol abuse. Mother has been able to manage her problem (6 years) but father is still struggling. He was involved in an automobile accident last year and his driver's license was suspended. He seems to be concerned and anxious about his business. He admits that he is impatient with Bobby and slaps him when he "mouths off."

In a play session at the Clinic, Bobby presented like a needy child. He was nervous and frightened (eyes wide open, ready or alert to protect himself). He is quite verbal, but uses his talking as a way of controlling. His three wishes were – that he would not have to attend shool, that he could have lots of money, that Tom was not in the family and that there would be no sickness.

In the Clinic classroom, Bobby appeared anxious and needed reassurance. He had a sore throat, brought throat lozenges. He experienced hand tremors until the medication was changed. he is off task most of the time. Appears passive resistant, when confronted with lack of task completion, responds with refusals. He can change his facial skin tone at will. He seems to set his own rules. When is interested in the task, there are no somatic complaints.

At home, Bobby likes to take electrical things apart, works on train set. He reads a lot. He takes violin lessons. Attends Sunday School with friends in the neighbourhood. Attended summer day camp last year. During the summers, Bobby goes to his aunt's farm with his material grandmother (started at age 4). He is reported to be problem free on the farm.

IMPLICATIONS AND RECOMMENDATIONS:

Bobby's difficulties have been developing over the years. I found this case complex, in terms of the established patterns of interaction.

a. Bobby is expected to fill an adult role in the family for brief periods of time (then fit back into his child role when father returns).

b. Bobby is resentful of Tom, who is receiving a lot of attention for illness and because he is involved in administering the medication.

c. Illness (and substance abuse) is used in the family as a way of coping with unpleasant experiences.

d. Bobby uses illness to avoid going to school.

e. Because he does not attend school consistently, he misses new work and falls behind. He realizes that he is not doing well and develops somatic complaints. The situation is a vicious circle.

f. Both mother and teacher are caught up in the circle, they can't assess Bobby's physical condition and they give in (thus reinforcing the avoidance).

A number of changes need to be encouraged in this family.

1. Bobby should not be expected to assist mother with injections. This point has been discussed. The medication will be administered while Bobby is at school.

2. Bobby cannot fill an adult role. He is confused about his identity. He worries about his mother's health and about the family while he is at school. He attempts to be a companion to mother. When father returns, he is pushed out and often reacts with belligerence and temper tantrums. The family will need professional assistance to change their patterns of interaction. A referral has been made to the Pysch Walk-In Clinic (George Smith) for family counselling.

3. The parents have been encouraged to listen to Bobby's somatic complaints but to be firm in their expectation that he will attend school. This expectation will need to be supported by everyone working with Bobby. He has good academic potentional which can only be realized if he an cope with his behavioral difficulties in a positive way.

NAME: Bobby
DOB: January 7, 1972

DATE: May 14th, 1981

PSYCHOLOGICAL ASSESSMENT

TESTS USED:

Stanford-Binet Intelligence Scale, Form L-M
Wechsler Intelligence Scale for Children (Revised) - Digit Span
Bender Visual Motor Gestalt Test
Harris Tests of Lateral Dominance
Rotter Incomplete Sentences Blank
House-Tree-Person Technique

TEST ATTITUDE:

Bobby had started taking Tegretol the day prior to his first testing session. This session was one of his best in terms of attentiveness and lack of restlessness. As a result, it was wondered if he was subsequently receiving Tegretol on a regular basis.

TEST RESULTS:

(For a summary of test results, see Appendix of Psychological Tests.)

Bobby's IQ of 114 on the Stanford-Binet Intelligence Scale, Form L-M, indicated functioning in the high average range of mental ability. This scale is significantly higher than that previously obtained on the Wechsler Intelligence Scale for Children - Revised (see Appendix of Psychological Tests), due to the relatively heavy verbal content of the Standford-Binet Intelligence Scale.

On the Stanford-Binet Intelligence Scale, Bobby passed all the tests at the eight year level and failed all the tests at the average adult level, exhibiting a greater than usual range of successes and failures. His strongest performance was registered in the area of judgement and reasoning, where he passed a majority of the tests up to and including those at the thirteen year level. Strength was also apparent in the areas of general comprehension, visual memory, visual perception and vocabulary/verbal fluency, where he passed all the tests at the eleven year level. No significant weakness was detected in the area of arithmetic reasoning. His weakest performance was obtained in the area of memory/concentration, where he was unable to repeat four digits in reverse order at the nine year level.

In view of Bobby's difficulty in the area of auditory memory on the Standford-Binet Intelligence Scale, he was administered the Digit Span subtest of the Wechsler Intelligence Scale for Children - Revised (WISC-R). His score on this measure was significantly below average, due, primarily, to the fact that he failed to obtain the mental set for repeating digits backwards. The same phonomenon was observed on certain items of the Stanford-Binet Intelligence Scale. For example, when asked to give two reasons why most people would rather have an automobile than a bicyle, Bobby gave two disadvantages of having a car. There were occasions, too, when he required a question to be repeated, because he had forgotten its content.

Additional testing in the visual-motor and motor areas was conducted with the Bender

Visual Motor Gestalt (BVMG) Test and the Harris Tests of Lateral Dominance. Although Bobby's performance on the BVMG Test indicated a significant lag in visual-motor ability, he completed the instrument in significantly less than the average time. He was, therefore, readministered the BVMG Test, with the caution to work slowly and carefully. He took slightly longer to complete the second BVMG Test, but with the same overall result. However, his errors were not identical on the two occasions and it is felt that his impulsivity, which he unsuccessfully attemped to control, was largely responsible for his weak performance on this measure. It is relevantto note that the quality of Bobby's written work also appears to reflect the detrimental effects of impulsivity. Bobby's performance on the Harris Tests of Lateral Dominance revealed no signs of directional confusion. His knowledge of left and right was normal and he appearedto have established clear dominance in his right hand, right eye and right foot.

On the basis of observation and personality assessment, Bobby appears to be an insecure, anxious, impulsive and easily frustrated youngster. What seems to be happening is that his home-life engenders and/or exacerbates these behavioral characteristics. It is understood that, while his father is working out of town, Bobby is expected to assume an adult role in the household. This responsibility produces anxiety, which interferes with his ability to concentrate on his school work, and provides Bobby with grounds for resentment at being told what to do at school. These behaviors make school difficult for Bobby and he responds by being sick. Being absent from school, and missing work, gives Rick additional reason to be anxious.

CLINIC CLASSROOM OBSERVATIONS:

Bobby was nervous and distractible. He was frequently "off-task," wither "tuning-in" to what others were doing or at his teacher's desk wanting to talk. Direct confrontation produced strong, passive resistance on Bobby's part. Invoking some type of logical consequence for failure to work enjoyed limited success, because Bobby knew that the bus came at 11:30 am. On tasks of indeterminate length, e.g. diary entries, it was helpful to specify a resonable, but easily attainable, quantity of work (e.g. "I want you to write three sentences, Bobby.").

Initially, Bobby had many somatic complaints, e.g. headaches, nausea, etc. Although it is likely that these symptoms were psychosomatic, it is not possible to say with absolute certainty that they were not drug-induced, since Pertofrane apparently caused Bobby to have hand tremors and a motor seizure (see Social Work Assessment). Bobby's complaints did diminish after he had stopped taking Pertofrane and had started taking Tegretrol. However, his teacher felt that this was mainly a result of the approach taken to his complaints, e.g. "That's too bad. Perhaps, if you get to work, it will take your mind off it." It does seem fair to assume that Rick uses sickness in an attempt to avoid unappealing tasks, since he registered no complaints when engaged in tasks he enjoyed.

SUMMARY:

The results of testing indicate that Bobby is functioning in the high average range of mental ability, with particular strength in the areas of judgement/reasoning, general comprehension, vocabulary/verbal fluency, vusual memory and visual perception. Significant difficulty was apparent, however, in the areas of short-term auditory memory and visual-motor ability. Bobby's difficulty in the former area appears to be related to concentrative problems, while that in the latter area seems to be exacerbated by impulsivity. It is felt that Bobby's homelife contributes to his anxiety, insecurity and resentment toward school and it is to be hoped that family counselling will help to alleviate some of his difficulties. RECOMMENDATIONS:

1. Arrangements have been made for family counselling (for details, see Social Work Assessment).

2. The importance of administering Bobby's medication on a regular basis has been stressed with the mother.

3. The approach to Bobby's ailments should be sympathetic, but it should be made clear that they are not an acceptable excuse for not working (see Clinic Classroom Observations).

4. Whenever possible, reinforce Bobby for looking well and for saying that he feels fine.

5. It is felt that a study carrel might be of benefit to Bobby in the classroom.

6. Possible alternative approaches to Bobby's misbehavior and lack of task completion will be suggested at the school conference on May 28th, 1981.

APPENDIX OF PSYCHOLOGICAL TESTS

NAME: Bobby
BIRTHDATE: January 7, 1972

1. Stanford-Binet Intelligence Scale, Form L-M; April 28 and May 1, 5 & 6, 1981

Basal Age: 8 - 0
Ceiling Age: A - A
Chronological Age: 9 - 4
Mental Age: 11- 2
IQ Score (1972 norms): 114 (High Average)

2. Wechsler Intelligence Scale for Children - Revised; January 21, 1981

Scalled Scores

Information	12	Picture Completion	13
Similarities	14	Picture Arrangement	10
Arithmetic	12	Block Design	7
Vocabulary	15	Object Assembly	11
Comprehension	12	Coding	1
(Digit Span)	(10)	(Mazes)	(-)

Verbal Scale IQ: 118
Performance Scale IQ: 88
Full Scale IQ: 104 (Average)

3. Wechsler Intelligence Scale for Children - Revised; May 7, 1981

Scaled Scores

Digit Span	6

4. Bender Visual-Motor Gestalt Test; May 6 & 7, 1981

Chronological Age: 9 - 3
Developmental Age: Approximately 8 - 0
Emotional indicators - impulsivity

5. Harris Tests of Lateral Dominance; May 6, 1981

	Rating
Knowledge of left and right	Normal
Hand dominance:	Right
Eye dominance:	Right
Foot dominance:	Right

6. Rotter Incomplete Sentences Blank; May 7, 1981

Themes:

a) Fighting:
"What annoys me is after I have a fight and I'm beaten up."
"I hate losing a fight."
"At school I have some fights."
"The only trouble is staying out of fights."
"I failed. I have failed. I failed once– that was a fight."

b) Poor self-concept:
"Other kids say I'm dumb."
"My mind is small. No. My mind is as big as anyone else's."
"I am small."

c) Anger:
"My nerves really get hot when I get mad."
"I am best when I'm not mad."

d) Male interests:
"I like motor cycles."
"Sports are fun!"
"I need motor cycle."
"I wish I was stronger."

e) Illness:
"I suffer sicknesses."

7. House-Tree-Person Techniques; May 7, 1981

- anxiety
- emphasis on the soma
- aggressiveness/hostility
- feelings of inadequacy/weakness/social impotence
- frustration
- desire to shut out criticism
- lack of adequate control

NAME: Bobby
DOB: January 7, 1972

DATE: May 27, 1981

LANGUAGE ARTS ASSESSMENT

ATTITUDE AND RESPONSE:

While Bobby was coperative and attentive under examiner direction, avoidance mannerisms (e.g.: attempts to engage in conversation, gazing about the room) were prevalent whenever independent work habits commonly expected of fourth-grade students were required.

ASSESSMENT TASKS AND TESTS:
ORAL LANGUAGE TASKS:

Oral expression on familiar topics (as part of the pre-writing stage for the written language tasks mentioned below) revealed a rambling tendency. Guiding questions were required to keep on task and assist Bobby to organize his ideas.

WRITTEN LANGUAGE TASKS

a) independent task #1 -

Procedure:

i) Discussion of background experience, accompanied by preservation of words and phrases on the chalkboard.

ii) Listening to related short selection, followed by further discussion and preservation of additional ideas on chalkboard.

iii) Directed to write at least three sentences answering the stated question, "What makes popcorn pop?" and provided with a list of possible words to use, i.e., steam, popcorn, kernels, popcorn maker, water, heat, pop.
Result: Bobby printed three words (Popcorn pops with) when left on his own. When the examiner insisted he dictate three sentences before dismissal, he quickly and satisfactorily complied.

b) independent task #2 -

Procedure:

i) and ii) as above, including preserved sentence responses.

iii) Directed to write a description of a pineapple with an imaginary Eskimo boy as a reader.

Result: Bobby fulfilled the task as required (three sentences, appropriate context). He chose to print (inadequate spacing between words very apparent). He did not copy preserved statements but did utilize spelling aids (no spelling errors in his appropriately constructed sentences).

c) independent task #3 –

Procedure:

i) and ii) as above.

iii) *Directed to write a paragraph (discussed form) of at least three sentences, answering the following questions/statements:

What is a shark?
Tell about the different kinds of sharks.
What do sharks eat?

*Provision was made for Bobby to express himself orally first.

Result: Eight sentences of varying structure were printed (Bobby's choice) in a paragraph (complete with indention). Although letter and word spacing were inappropriate, i.e. often spacing between letters within words was greater than between words, accurate spelling assisted readability. Bobby displayed a feeling of pride in having completed the task in the set time.

d) independent task #4 –

Procedure:

i) Listening to a story.

ii) Retelling of story orally in his own words, with key words/phrases written down by the examiner on a small piece of 'planning paper' (used as an aid for writing).

iii) Directed to write the story in a set time.

Result: Bobby completed this task before the set time. Once again, he chose to print (capital letters sometimes used inappropriately to begin words within the sentence), spacing remained a problem yet context was readable due to accurate spelling. A suitable, original title was written voluntarily.

SCHONELL GRADED WORD SPELLING TEST - FORM A:

Grade Score: 4.7

Errors suggested the need toattend to visual imagery of words, e.g. 'hopd' for 'hoped'; 'concerte' for 'concert'.

CURSIVE WRITING:

Upper and lower case alphabet sequences in cursive writing were done slowly. (It should be noted that when given the choice on tasks, Bobby chose to print.) Execution of lower case forms revealed difficulty knowning where to begin.

Rick lacked the knowledge to form the following capital letters:

B, H, D, J, K, L, N, P, Q, R, S, U

Rick's handwriting, considering individual single letters to entire words, was characterized by:

1) inconsistency of slant and smoothness of stroke;
2) difficulty in mantenance of letter size and use of baseline.

Although Rick's grasp of the pencil in his right hand was rather tight, finger grip and positioning were satisfactory.

McCRAKEN STANDARD READING INVENTORY FORM A

Response to graded selections read orally or silently, followed by unaided recall and direct questions, indicated:

1) word recognition accurancy and comprehension at an independent level on a fourth-grade selection read orally.

   Comprehension of a fourth-grade selection read silently was at an instructional reading level.

2) a fifth-grade selection read orally was decoded and comprehended at an instructional reading level.

   A fifth-grade passange read silently was, as well, comprehended at an instructional reading level.
   While word recognition was at an instructional level on a sixth-grade passage read orally (with very poor phrasing), comprehension was at frustration level.

3) a tendency to omit or insert small words, usually having no effect on

meaning.

4) direct questions were essential because, although unaided recall was sequentially accurate, it was never complete.

SAN DIEGO QUICK ASSESSMENT (SIGHT VOCABULARY):

Response to isolated words presented in graged lists revealed a solid fund of sight vocabulary (100%) up to and including fifth-grade level. Seventy percent accuracy was obtained on a sixth-grade list.

SCHONELL GRADED WORD READING TEST FORM A

Grade Score: 6.9

As on the above test, Bobby's response was quick and totally accurate to a late, fifth-grade level. When encouraged to mediate, as permitted on this instrument, Bobby successfully decoded words such as 'plausible' and 'conscience'.

RECOMMENDATION:

WRITTEN LANGUAGE DEVELOPMENT:

A. General Overview

Bobby would benefit from daily, individual assistance with an emphasis upon written language. Consideration might be given to:

1. one-half hour periods where there is an expectation of beginning and completing a written assignement. This procedure worked well at the Education Clinic. Many successes will be necassary for Bobby to develop a feeling of task completion capability.

2. extending Bobby's knowledge of and facility with cursive writing.

Further formal instruction and practise with cursive letter forms, joining of letters, etc. might be attended to during early assistance sessions.

B. Suggested Procedures

1. Select a topic about which Bobby possesses some background knowledge.

2. Discuss what he knows about the topic, preserving his ideas first nearly verbatim, moving to phrases, then to key words. This step serves to:

a) indicate to Bobby that he has knowledge or ideas about which to write

   b) preserve oral language to provide an idea reference as well as to assist with spelling, and

   c) move from ideas expressed in complete statements to key words as an organizational technique for written language.

   Assist Bobby to focus his attention on the topic by initially working from questions printed for him to see. Move to phrases, then key words thus assisting him to organize his responses.

3. Read a short selection to Bobby which is related to the discussed topic. Selections from the New Practice Readers by Anderson/Sone/Burton were found to be appropriate.

   Topics should be both factual and fictional. While factual topics lend themselves to organizational emphases, e.g. what, where, when, etc., fictional material might be first heard, then written in Bobby's own words, an ending written etc.

4. Discuss additional information, including it with the earlier, preserved ideas.

5. Assign the written task, providing:

   a) audience, and intent

   b) specific directions are length e.g. at least three sentences, etc.

   c) first printed questions, then phrases, then key ideas around which to organize his idea

   d) only guidance, requiring Bobby to jot down phrases/words and to number them for organizational purposes. A small piece of paper is useful.

6. When Bobby has finished his draft, ask him to:

   a) read it silently to see if it says what he intended

   b) check to see whether he included all the key ideas he intended

   c) proof-read for limited purposes regarding conventions of written lanuage, e.g. spelling, punctuation, capitalization, etc.

7. Provide opportunity for Bobby to share his writing by:

   a) a reading it to others

b) typing it for reading purposes, etc.

This provision seemed to really boost his motivation and self-esteem.

8. Require good writing work habits (support of page, appropriate posture, etc.).

9. Teach required writing conventions e.g. indentation, quotation marks, etc.

Please find enclosed typed written work done by Bobby.

NAME: Bobby

DATE: May 26, 1981

C.A.: 9 years 3 months

HEARING, SPEECH AND LANGUAGE

PERTINENT BACKGROUND DETAILS

No articulation errors were detected in 1978. At that time, Bobby did not appear to have short term memory weaknesses, but he had some difficulty imitiating clapped rhythms. Never weak, his reading skills have shown progressive improvement over the last three years, in both decoding and comprehension. His general verbal abilities are strong.

There is a prolonged history of an inability to concentrate, and constant approaches to the teacher; in class, Bobby is disruptive, and although he likes to contribute to discussion, he seems uninvolved as a listener. Occasional immature speech is noted.

CLINIC ASSESSMENT:

SPEECH, HEARING AND AUDITORY DISCRIMINATION:

Puretone thresholds were obtained bilaterally using an audiometer. Those for the right ear ranged from 0 to 10 dB, well within the normal limits. Similar readings were obtained for the left ear with a dip in acutity in the upper frequencies, amounting to a threshold at 15 db (2000 Hz) and two at 20 dB (3000, 4000 Hz). Both premature and prolonged responses were noted during the assessment.

Spelling, reading and word recognition have not been difficult for Bobby, and his auditory discrimination skills in the area of word compositions are strong. (One error: Wepman Test Form 1A). In five test items he revised a first automatic decision that was not correct. No speech disorder was obvious.

AUDITORY SEQUENTIAL MEMORY:

In spite of his frequent comments or questions during its administration, Bobby was able to repeat back sufficient sentences either intact or with a fair degree of accuracy – so that he reached the 8 year 6 month age level with the Detroit #13 Subtest (Auditory Attention Span for Related Syllables). He made no errors repeating statements in the Basic Concept Inventory (Englemann), but showed a slight tendency to perseverate when repeating numerals a certain number of times, e.g.: 7-7-7-7-, 4-4-4-4; Rick perseverated 7 to a 6th repetition. He attained an average level repeating unrealted words.

GENERAL LANGUAGE CONSIDERATIONS:

Bobby scored well above his age level in a task where he had to complete verbal analogies; he generally gave two alternatives in his response, although this did not benefit him at the level where the items became too difficult for him. Where the analogy was presented pictorially, with four alternative solutions being provided, Bobby again coped readily.

I.T.P.A. Auditory Association – Above 10 years 11 months (test ceiling)
I.T.P.A. Visual Association – Above 10 years 3 months (test ceiling)

Bobby's score in a grammatic understanding measure exceeded test ceiling, and indicated no weaknesses. In conversation, such slips as "I've rode" occurred.

T.O.L.D. Grammatic Understanding – Above 8 years 9 months (ceiling).

Some comprehension difficulty arose in the Token Tests and the Basic concept Inventory. This was specific to confusion amongst behind/under/in front of/on top of, and between next to/on. Bobby also interpreted instructions to "touch" objects, as meaning that he should have them "touch each other."

Although Bobby displayed some flexible thinking, his analysis of a situation did not cover all solutions where 2 or 3 alternatives had to be given, e.g.: interpreting "the ones that are not the biggest," "the man is not falling." He did not discriminate completely between known, real facts, and guessing or ascertaining from clues – in the specific instances he followed inappropriate clues.

SUMMARY AND RECOMMENDATIONS:

1. The mildly depressed auditory acuity of the left ear should remain under observation. (i.e. retest in September)

2. From the above, Bobby does not appear to have an auditory memory weakness per se, but one needs to be aware of his tendency to perseverate. He is able to retain a statement heard, long enough to correct a first response which he may have made automatically, without reasoning. Sometimes Bobby may notice his own error, monitored by a third party. (The psychologist's digit span results are at variance with the observation that Rick has no memory weakness – the concentration problem would explain this difference.)

3. It is suggested that Bobby needs some specific training in the interpreting of the prepositional terms: next to, on top of, underneath, behind, in front of. Two or three 5–10 minute sessions using counters, coins, pencils, or other objects would probably suffice.

4. Some lessons might be structured to assist Bobby to differentiate between fact, the conclusions possible when facts are clear, and fiction or imagined inferences. The Line between possible, probable, and impossible does not seem to be a clear distinction for Bobby.

5. Psychological testing has shown that Bobby has, indeed, strengths in judgement, reasoning and verbal comprehension. Although his responses to questions may be accurate, and sufficient, other children can add more facts and opinions. Bobby needs to be asked to paraphrase the responses given by his classmates; this should become a regular routine. with lack of such structure, and too much space in which to perform, Bobby remains liable to become too uninhibited.

APPENDIX C
REFERRAL FORMS

DATE____________________

REFERRAL - DIAGNOSTIC CLINIC

CHILD's NAME__________________D.O.B.___________SCHOOL______________

GRADE/CLASS__________TEACHER___________COUNSELOR____________

NURSE____________PRINCIPAL___________PARENT/GUARDIAN____________

ADDRESS____________PHONE: HOME___________BUSINESS____________

CONSENT OBTAINED? YES____

NO____

SECTOR_______________SECTOR TEAM CONTACT PERSON_________________

OTHER AGENCIES/PROFESSIONAL INVOLVED:___________________________

____

REASON(S) FOR REFERRAL, SUGGESTED AREAS FOR INVESTIGATIONI REQUESTED SERVICES

____

____

____

SCHOOL PSYCHOLOGIST

____

____

____

SCHOOL SOCIAL WORKER

____

____

____

READING SPECIALIST

____

____

____

SPEECH CLINICIAN

ENCLOSURES:: Psych. Report____Reading Report____Social Worker Report____Teacher Report____ Other____

FIELD TEAM PRIORITY FOR CLINIC STUDY:________________________________

____

DISPOSITION BY CLINIC:________________________________

____

____

DATE________________CLINIC REP.________________________________

INTAKE SUMMARY

DATE________________

NAME:____________________ SCHOOL:____________________

BIRTHDATE:____________________ ADDRESS:____________________

AGE:____________________ TELEPHONE:____________________

PARENTS:____________________ PRINCIPAL:____________________

ADDRESS:____________________ TEACHER:____________________

TELEPHONE:____________________ GRADE:____________________

REFERRING SECTOR: ____________________

LIAISON: ____________________

CORRDINATOR: ____________________

CLINIC ADMISSION: ____________________

REASONS FOR REFERRAL:

INFORMATION FROM CUM CARD:

INFORMATION FROM BUREAU FILE:

INFORMATION FROM CLASSROOM TEACHER:

DIAGNOSTIC CLINICE

TEACHER REPORT FORM

Student's Name:______________________________GRADE:__________________________

School:______________________________Teacher:________________________________

Reading Teacher (if different from above):__________________________________

---

1. (a) Is the child currently working with:____a teacher aide,
____a resource teacher,____a volunteer,____a tutor,
____a counsellor

(b) If not, is there a possibility of this child working with:
____a teacher aide,____a resource teacher,____a volunteer,
____a tutor,____a counsellor

II. ACHIEVEMENT	(include test informataion)	Materials (include series, titles and levels. Comment on ability to handle these.)

READING:

WRITTEN LANGUAGE AND SPELLING

ORAL LANGUAGE:

MATHAMATICS:

OTHER SUBJECTS:

Is there any classroom work in language arts or mathematics you would like the Clinic teacher to continue with this child? Please specify.

(N.B. We connot guarantee that all of this will be completed.)

III. ATTENTION SPAN, TASK COMPLETION, WORK HABITS

If you have tried any special techniques to deal with specific problems, please mention.

IV. ACADEMIC STRENGTHS, MOTIVATION, INTERESTS

V. RELATIONS WITH OTHERS

(fits in? isolated? etc.)

VI. PARENTS' ATTITUDE, AND INVOLVEMENT, MEDICAL PROBLEMS AND/OR OTHER CONDITIONS AFFECTING CLASSROOM MANAGEMENT

VII. COMMENTS – SCHOOL COUNSELLOR

____

____

____

____

____

________________	________________	____________
Signature of Principal	Signature of Teacher	Date

APPENDIX D

SAMPLE FIELD NOTES

Field Notes:	Reflections
Home Visit:	Bobby
Date:	April 15, 1981

Initial home visit at the home of Bobby. Plans were well organized, the mother was receptive and the interview was open and frank. The tape recorder was checked at the beginning of the interview and appeared to be recording. Unfortunately, the tape was defective and did not pick up a great deal of the interview. Intensive frustration was experienced due to the loss of valuable data. Extensive field notes and observations were subsequently made that evening to record observations due to the fact that a tape was defective. The tape was borrowed from the AVMC. As a result of this experience, the researcher bought a set of ten new tapes and decided that only new audio and video cassettes would be utilized for the remainder of the research.

Field Notes:	Reflections
Activity:	Attempts to improve the inside operation
Respondent:	Betty, Social Worker at the Clinic
Date:	April 22, 1981
Time:	12:45-1:00
Place:	Returning from an interview with a mother

Betty described that there would be a 'team meeting' later in the day to discuss improvements within the Clinic. She indicated that she felt that she and the speech pathologist seem to have the 'burn-out' syndrome with respect to thinking of new ideas for making the operation work better. Apparently since two new team members were assigned to the Clinic this past year, several suggestions have been made to improve the procedures for operation. One of the primary examples given was the compiling reports. Last year when an established team was together attempts were made to compile very comprehensive reports. "They were masterpieces." However, Betty indicated that they took a great deal of time to compile and the new specialists felt this was a waste of energy. A new format for report writing was suggested by the new members of the team. Ths social worker was most pleased that this suggestion was working very well and saved a great deal of time for the team as a whole. She wondered what new ideas would be presented for improving the operation.

Field Notes: Refections
Activity: The first Progress Meeting
Date: April 21, 1981

It appears that the specialists are generally quite formal. The researcher wonders if this is because the specialists are not clearly aware of the objectives of the research project. The reacher has attempted to be open regarding the nature of the research. There is a question as to whether the rather formal atmosphere has been caused by the researcher's presence.

Field Notes: Reflections

Activity: Interview with three of the field specialists
Time: 1:00-3:30
Date: April 22, 1981

An interview schedule was set up with three of the specialists who had volunteered to give their responses to questions relating to the impact of service delivery. All of the specialists were comfortable within the interview but a phenomenon was noted. In counselling they call this type of phenomenon the doorknob syndrome. It seems that in a counselling session the client will often wait until leaving, with his or her hand on the doorknob, before saying the most important statement which has not been said due to reasons of blocking.

During the interviews two of the field specialists waited until after the interview to indicate that they felt that all of this assessment was really very, very useless unless more emphasis was placed on programming. One of the specialists also noted that she felt a great deal of money was being wasted due to the fact that heavy emphasis was placed on diagnostics and not enough emphasis was being placed on the recommendations and the treatment or the carrying out of remedial procedures which were supposedly to result from the intensive diagnostic situation which had been the purpose for referring to the Clinic.

Field Notes

Activity:	Discussion with the diagnostic teacher
Respondent:	Leanne
Time:	11:45
Date:	April 27, 1981

During the noon hour Leanne described to me what had taken place at the progress meeting on April 22. She indicated that the team members were all trying to work on more efficient operation within the Clinic. They had felt that having two meetings, two complete afternoons a week, one on Tuesdays for the purpose of intake and to discuss current case histories and to share information as well as another meeting on Wednesday to discharge two children had taken too much of the specialists' time. As a result, the psychologist and the reading specialist proposed the following changes in terms of the operation of the Clinic.

They decided that they would combine the discharge meeting and the progress meeting and have these meetings on Wednesdays of each week which would give the specialist within the Clinic the other four days to complete phone calls, home visits, report writing and liaison with outside agencies. It was decicded that during this progress meeting which would be held each Wednesday there would be no phone calls taken by any of the specialists. Apparently there were many disturbances in previous meetings which caused other specialists to have to wait and unnecessary time was being wasted. Another rule was instigated which indicated that each specialist as well as the Education Clinic classroom teacher was to be on time for all meetings which were to begin at one o'clock. As well, in terms of the case presentations when information was being shared regarding the test results, if two cases were to be presented before recess to discuss the on-going progress of the child in the Clinic, each specialist was to have a ten minutes time frame to disseminate information regarding test results. At the end of the ten minutes, a timer was set and this timer would ring indicating a period of questioning was now open to the other specialists regarding the particular specialist's findings and interpretation of test results. As well it was decided that rather than giving a total social history for the incoming cases, that the social worker would now simply type out the social history and each specialist would be responsible for reading this document before entering the progress meeting. Any additional information could be presented within a short ten minute period of time by the social worker.

Field Notes

Activity:	Team meeting with the Director
Subject:	Reorganization
Time:	1:30
Date:	May 13, 1981

Mary brought up the point that it was difficult to organize time due to constraints regarding the testing schedule. She presented a three alternatives were written in a proposal. She indicated that the proposal for new intakes would cut down intake by 25 percent. Proposal A would produce three-quarters of the current intake, proposal B would produce three-quarters of the current intake and proposal C would produce 83 percent of the current intake.

The reading specialist stated that this change was essential as she believed that it is impossible to follow up diagnostic teaching suggestions in the current organization.

The director of the Bureau indicated that the team at the clinic take the proposal further and prepare additional and more specific suggestions. The supervisor indicated that the budget for the coming year was settled, however there were some programs that had not been completely organized. The ESL program for next year is not completely approved. There is an additional $75,000 to implement this program which would mean that the screening of placements would be taken on by another team other than the bureau staff.

The difficult case of Eric was discussed extensively. The director of the bureau indicated that the impact of clinic service must be looked at. He suggested (a) report our activities, (b) make more specific recommendations for the meeting in June regarding new proposals for restructuring the operation in the clinic and (c) note details for changing structure. The director of the bureau suggested that field teams be consulted in terms of discussing changes before September. He seemed to feel that we must document what we are doing in terms of impact on the system. Follow up is important. Joe believes that there are political reasons for documenting impact. He feels that the school system as a whole is trying to make schools themselves responsible for more specialized programs. Ironically the schools are often overworked and are unable to take on added responsibility even in terms of specific recommendations. He stated clearly, "Every time we change a bloddy system it takes the personnel three years to learn it."

Field Notes: Reflections
Date: September 1, 1982

The use of a conceptual model for describing qualitative data has been found to be an awkward and restrictive method of presenting the data from which this study evolved. One of the problems which was encountered was the fact that the literature review and conceptual framework were fully developed before an attempt was made to write chapters involving narrative and verbatim quotes from the research setting. If the research were to be rewritten, the researcher would begin by writing a rough draft of the body of the thesis and subsequently allow the literature review to develop from the ideas which evolved. It is concluded that an approach similar to the work of Glaser and Strauss (1967) based on grounded theory may be an easier method of dealing with qualitative research data.

Field Notes: Reflections
Date: November 1, 1982

After struggling with the idea of developing a new format and categories for the thesis, it was decided that the use of the conceptual framework would be maintained. The categories which would have emerged using the grounded theory approach (Glaser and Strauss, 1967) would have been similar to the preconceived categories which were used. Although new categories may have altered the problem of blending narrative, and a conceptual framework, inferences regarding the delivery of clinical service would remain unchanged. Therefore, Van De Ven and Ferry's (1980) model may be considered a useful technique for studying interorganizational relations although the model seems to be more suited to handling quantitative rather than qualitative data.

APPENDIX E

SAMPLE TRANSCRIPT OF MEETING

Sample Transcript-Meeting

Activity: Clinic Staff Meeting
Respondents: All Clinic Staff and Director
Date: May 12, 1981
Time: 1:30
Setting: Clinic Conference Room
Code: S(P) Psychologist
D Director
S(R) Reading Specialist
S(SW) Social Worker
S(Sp) Speech Clinician

S (P) In leading up to the . . . we're finding it very difficult to survive time-wise and this isn't talking about school time or school hours, and this is kind of a summary of . . . As an average between the four of us, we get each kid during the whole clinic stay for three and three-quarter hours and we're finding this a problem, especially in terms of the things in number two. It seems that, especially number a, schools now seem to be having their lunch hours at 11:30 and when we go to school conferences which . . . for noon hour, if it's and extreme part of the city from here, then sometimes we have to leave as early as eleven o'clock. We have at least two of those a week, sometimes more . . . plus the other thing that the children actually have to get on the bus at 11:30 so the cuts into the time. The long weekend again cuts into the time. The parents of the children and the teachers who come to clinic, this is in the morning, and you have to schedule for them as well, so what has been happening is that it's been difficult at time to complete assessment and children have been kept over but that kind of stockpiles the problems. And even, this has happened not to me personally, but . . . complete the assessment and we seem to have so little time as it is that that really seems inefficient. I suppose something that came out of the visit from the man from Saskatchewan, from their clinic, was that they keep their kids for four weeks for assessment and that caused us to look at the idea against ourselves and that would be pattern a under number four, proposed alternatives. Now the impact again . . . is quite substantial. It would reduce our numbers to 75% of what they are this year or any other year. The second pattern (b) happens to be there because interestingly enough, it's a much smoother one than number (a), but time, in terms of numbers and so on. Pattern c, an intake pattern of two to one, would help somewhat. It would have the impact of reducing numbers per year to 83% of current numbers. There doesn't seem to be any way of getting more time without having an impact of course on the total there. Something I did do, I noted on . . . I'll stop talking in a minute, now because the . . . say how they're thinking, but I phoned John about two weeks ago, I've never worked so hard in all my life for . . . looking forward to weekends and evenings so . . . even when I was at university, and I phoned John to see whether, somehow or other, someone did finish packing and he said he understood precisely what I was saying and he said in his perception things were hectic enough but seemed to get much worse after we started. So just that interest– I phoned downtown and got the lists for the last four years prior to this one, 1976/1977, that's the back page . . . clinic statistics just to see if John's perceptions were on during John's first year here, which was the transition year, we can't get an figures prior to that, there were two reading specialists, two teachers, one and a half psychologists, one social worker and one speech clinician and there output for that year was 67 cases.

D That's when they were all here in this building.

S (P) That's right.

D In two classes.

S (P) That's right. And so, you know, John was right. He would have done, he told me, approximately 45 children that year and Ann. . . half time person would have picked up the other 22. So that was the reason that that is there.

D Your options a, b, c. A would produce 3/4 of the current intake.

S (P) That's right. I have

D B would produce what?

S (P) The same.

D Three quarters and the other would produce 83%.

S (P) Yes. And I suppose just to finish off . . . these kinds of ideas . . . looking at the middle page and I think that some of these things can be . . . just to mention how pressured out time is, some of the things that we've tried to do here. We have put out progress and discharge meetings together and Frances brings in a timer and we get so many minutes each to speak, the timer goes off and you're supposed to stop. We're tried to dissuade people from making case presentations from the field unless it's really something special but like I find it– the things that you were talking just now about something that really interests me– the idea of being able to do the kind of followup where you're . . . helping with program and really making an impact after the child leaves. And that's where I known that I could do a lot more but just don't have the time to do it. In fact to do things as they are in what I consider an adequate way I don't know how many years one could servive under the present regime.

D And none of this of course

S (P) These are just our special functions– the ones I consider . . .

D None of this accounts for your sort of follow-up functions unless you're

S (P) NO, not at all, no.

D Which is . . . in getting funding this year, in particular . . . still this concern about the amount of staff time that's going into the number of children. If something touches like a field team, if it touches 500 kids, no problem justifying funds. If it touches 60 kids, there is great difficulty in justifying funds. When I- still . . . touch 140 kids with the follow-up activity, then well, you know, maybe. But they look at this always in terms of ratio.

S (P) But they have to look at all . . . of the service.

D Oh yes.

S (R) And also, just thinking of Billy Joe. . . . If assistance is given to him, it's not just a reflection of one child but hopefully the entire class is going to benefit from his absence or whatnot. And that's true of any help that's given to children who are far less needy than this particular child.

D That may suggest then some addition or some other way of reporting what we do.

S (P) I think that's . . .

D That is, the impact of- sort of an impact statement. You known, the simple minded guy that I am, all I've been able to think of is you count cases that you work with . . . never really thought of that impact question.

S Joe there's something else too. Like just one particular case, Billy Joe, has been a really heavy one for me this year. I hat to think- I probably haven't kept good enough records because sometimes you're just too darned busy to write down what you're doing but it's taken me hours and hours probably in terms of days for that case. He's at Lac La Biche now and I'm still involved in it. We don't at the moment have a place to record how many contacts with a particular case. He is just one cross on the list and it could have been a half hour telephone call. It hasn't been, it's almost been like a part-time job.

D Another year, we're looking at . . . much more elaborate system of reporting than we've been using.

S (P) Actually Janet made a stab at that. You might like to, I mean not right now, but-

D The request from the Superintendent was that we be in a position a year from now to report to schools the amount of staff time that we've devoted to each school which will involve a sort of time charge in each case that we work on and then summarizing them by schools. So would you do perhaps a bit of creative work for me here in terms of looking at this year – if you can, you may not even be able to now – I find you can't report information that you don't collect, that's a cardinal rule, so you may just say, O.K., in retrospect, what we should have been doing is counting charging hours or something of this nature. We have to report this year exactly the same as we always have but it would help me in something larger than clinic by thinking about how this kind of impact work could be better recorded and therefore better reported when I get back to the budget problems again.

S (P) Joe I've got two things that I would like to say. The program suggestions that Janet prepared almost form a kind of syllabus, you known.

D Yes.

S Manual that the teacher can use for general group programs.

D More than one.

S (P) Yes. And one of my recent follow-ups I had prepared kind of a teacher feedback form so that the teacher could feed back actually specific, you know, relating back to the original report that went back might be helpful because I think if we were to somehow tap the teacher reactions to the materials that they are being provided with, we might get evidence about the home class benefits more. My therapy cases –

D And that of course, in terms of . . . really important, that you're structuring the respondent's response. You can acturally think about and consider what you said and their head processes that kind of stuff . . .

S (P) We've been trying to do it, I suppose, in a sense too, that when we go for our conference with the school to educate the teacher, in other words not just saying something like the kid has . . . integration difficulties but saying how these are apparent in their written tasks and so on so that the next time the teacher sees writing of that kind they know what sort of thing it is and could do the recommendations received before for that problem. . . . I guess the bottom line again here is that like three and three-quarter hours, it's not unusual for the kind of kids we have to take like three and a half hours on the Binet or something but when I was counselling in the schools I did a lot of testing because it was called for and I don't think anyone ever said to me that's all the time you've got for that. And this is an in-depth service here and that really bothers me, you know, they're sent here for an in-depth assessment and . . .

D And I'm not sure we're providing it.

S (P) Right.

S (R) If I could just follow . . . In my work I have to scramble to get the assessment done and where I really don't have time is to follow up either with Frances or even for myself enough in a diagnostic teaching situation. You really feel . . . but a number of my suggestions are the right ones that should be tried.

S That's true for me . . .

D With respect to your first page, the only thing that I seem to query is to me the statement that two conferences are at noon and therefore to cover them you have to leave as early as eleven. It schools dismiss now at somewhere between 2:15 and 3:30, why is it necessary to have school conferences at noon?

S (P) The reason is that after school ones are really unpopular with the staff.

R Yes, they are, um hum. With the school staff.

S (P) Yes.

D They think their day ends at 3:30 do they?

S (P) I don't know if they think that or whether that's when they're ready to take a break or I don't know, but it is unpopular.

D And so you'd encounter resistance if you did . . .

S (R) I would say my impression this year has been very favorable towards school personnel. I think we have been treated very fairly.

S Um hum.

S (R) But it's just as Mary pointed out, a real time limitation for us, I mean, invariably we give up our own noonhour but that's

D Yeah.

S (R) That's beside the point, but it's just that it also eats into either testing time or even going over the files to prepare for what you're you going to do in testing for tomorrow.

S . . .

S . . .

D The schools' lunch hour . . . do schools typically have an hour for lunch?

S . . .

S (R) An hour and a quarter . . .

S But we usually go . . .

D Do you find that it's uncommon for the schools to arrange working time for the conference.

S . . .

D They claim they can't?

S Yeah.

S (S) We haven't requested if often – I haven't, but you know they arrange for the teachers to come in here and usually make internal arrangements to cover for the teachers.

S (P) That's even been a problem this year though Kate, I have teachers whose schools felt that they couldn't make arrangements . . .

D I don't want to . . . time to hassle through all the detail here but what I would suggest is that you take this a little bit further and internally, if not now, then before the end of June, put together a series of recommendations about what you'd like to do for another year. I would be prepared to go to four weeks. I don't much like the sound of reducing numbers but that may be necessary. I think we've got to, I also think that we're going to have to ask the schools through our sector teams to make a bit more of a commitment on these cases if they want us to work on these cases. I don't think it's up to us to do everything at their convenience.

S (P) Joe, there is a problem with keeping them for four weeks in the sense that it cuts more in, yeah, it might be possible to make a joint . . . although I could see the reasons for wanting to go to the four weeks. But we're already booked up until –

S . . .

S (P) We have got . . . Haven't we. I can see the point. It seems we have more . . . referrals . . . but what I'm saying is, there might not be enough places.

D There's another way too, another thing that we could consider and that would be to do something that we did three or four years ago is to run a couple of predetermined periods during the year for certain classes or kinds of cases. Collect a batch and bring in five or six at a time. In other words, we are essentially locked into one mode of service here with a limited amount of external consulting and in airing a proposal for another year why not consider if there are any . . . fresh approaches that would have effect on . . . more kids in more schools with less intensity than . . . we've got now while at the same time increasing the intensity on those cases that need it and, you know, one example is . . . school offers to work on the case or a sector team . . . it's a bit dumb that we have to shut everything down here at eleven o'clock to suit the convenience of the school's . . . it seems to me that they either make some arrangement to break the significant teacher from that school, the teacher particularly, . . . during some working time or they do as the rest of the staff do which is to sit down at half past three and do some extra work. If you have to work three nights a week or five nights a week, nobody –

S (R) I'd be pleased to work two nights a week . . .

D Nobody asks you, you do it, that's . . . Prepare some recommendations for next year, you've outlined a number of options and I think we should spend really a half day on plans for next year. Now if you prefer to set this aside for now and come back and talk about it some more, we could try to work these through point by point . . . to do that later, otherwise you may want to try to decide among yourselves about things you really want to recommend.

S (SW) I'm sorry I missed the part where you were discussing the things . . . suggested here. Do we have any kind of a mandate for taking in a certain number of kids?

D No.

S (SW) I didn't think so.

D There's no rule from

S (SW) So that if we say, you know, we take the kids that are comming in for September and October that are booked

S . . .

S (SW) . . . so that we could look at the 2-1, 2-1 . . .

D The only real concern

S (SW) . . . good job.

D The only real concern that I have is . . . numbers that I mentioned at the beginning. It's difficult to assure funding when the impact of the program is limited to relatively few children.

S (SW) Well what about the developmental program? How many kids do they take in?

D The same problem.

S (R) I think though, like from the teacher's point of view, if you've got twenty, well thirty children, and one of them is giving you an immense amount of difficulty and you don't know quite just quite to do. Just some help with that student helps you relax and know what to do with the other 29, so I really feel that if we're doing a credible job with one student in a classroom, that we're likely helping the others in the class and I really don't think that that's . . .

D O.K. But think like the Superintendent and you've got $200,000 being spent – that's $3,000 a kid – which is as much almost as the total cost of educating a kid . . . and that's the kind of thing you have to deal with. Now if we can turn around and say well we have 50 kids or 60 kids treated intensively and in addition we have consulting or group consulting kinds of practice on another 100, then that changes the ratio . . . and removes most of the . . . In other words, I know that there would be this kind of support from individual teachers and individual principals if clinic were to be banged on the head(?). Nobody denies that it's a useful service and appreciates it, it's a question . . . terms if the system cannot fund it. As it happened we didn't have any particular trouble this year but we did last year.

S (SW) And we worked our buts off last year in terms of the numbers.

D Yeah, and there's always a concern about – it probably doesn't make that much difference whether it's ten more or ten fewer but if we really looked at some way of dealing with this issue of impact because that's the political . . . and I'm not saying that that's what precedes these things but it is another factor.

S (P) If we could, say, arrive at the number of hours that is the average for each child that is assessed and have taken the other sort of stuff or even an average for out of clinic type work, we could have number equivalents which for somebody like Philip . . . would amount to about six children or more, that would be one way of

D For schools could be weighted for four children.

S (P) O.K.

S (Sp) And I would like to mention the speech therapy cases I see, which to each one I go twice a week and also doing coordination and followup for those children at the same time. And I'm now counting that in both sections because it isn't just speech therapy.

D O.K. Well I think we've sort of, as they say, shared views on this one enought for now and the follow up would be of two parts: one would be to report you activites this year as creatively as you can, you know, do some of the things we've been talking about and also to set up plans for collecting information for next year that might be a little more sophisticated than that we've been doing up to now and secondly, either decide to table this matter and discuss it at a further meeting or special meeting or else for you guys to figure out and make some specific proposals for another meeting that we could deal with and I won't have a lot of time until perhaps the last week of June. I have to go away for a week or ten days in mid– but I expect that I would have some time that last week of June and I would like to have our plan more or less in place . . .

S (P) Joe, am I right in thinking that the reason you appear to favor the . . . because that means that you're always full in the old sense of the word.

D No, I don't favor one over the other, any one of those would be all right.

S (P) I thought in one sense that the rationale is easier for the average person to follow.

D Well I do know that as long as I've been associated with the clinic, which goes back to about 1967 or 68, three weeks has never been long enough and I think the assumption that . . . was well, if we did four weeks, then for some cases four weeks wouldn't be long enough, or even five and indeed we've always know there are some cases that you do need to extend beyond the . . . We've always had that privilege, the thing was though the pace that you were into and that keeps on and so you could argue what we look at is the intake pattern and then keep the amount of . . . any particular kid as somewhat flexible. How many Frances can manage. Whether that really is six or more than six is another question.

S (P) But if you went to a and kept them for four weeks, we'd be in exactly the same position time–wise as we are now with six in three, the ratio's the same.

D But if you did do something with this noonhour, you could increase you assessment time here by an hour a week.

S (P) The trouble with . . .

D Yes. And that's . . . keeping it at six.

S . . .

D Well we're getting into the details.

S Yeah, that's true.

D We'll do that . . .

S (R) Just before we leave this, I would like to make a comment that I think we owe Mary a great amount of delving into in a numerical way trying to understand why we seem to be running and never catching ourselves.

D That's a very good . . .

S (R) Mary would you like to speak to . . .

S (P) I attended Sector 12 on Monday morning because it has been a concern to me that we haven't had clinic cases from that team at all this year and I had the excuse of a followup with one other little boy, Tristen . . .(?) that we had earlier this year and who we'd had back in again for a week and who had changed sectors and is now within Sector 12. One of the comments that was made by the team about nonrequests for clinic placements, they did say that they had had requests from schools for clinic placements but on reviewing themselves had felt they could deal with them and had discouraged referral to the clinic. The other reason that was brought up for non-referral of cases was that they had their team meetings on Monday mornings and the huge host of referrals to them are their first priority and constraints and they just don't have time to prepare a clinic case. Amongst their reasons was the complications of referrals to the clinic, how the intricacies of the referral system was a discouraging factor.

D This is Ruth's interpretation now?

S (P) That little bit came from Ruth. The intracacies.

S s . . .

S (P) We had a one hour session and I asked what they would require of the clinic and what they would want it to be doing for them. One suggestion was programming in depth which I described – I then mentioned that was what Janet in particular was doing this year and of course the team was not aware of that because they had seen no report being witness to none of our school conferneces. The kind of requests that Ruth had were to a large extent met by what you do Jan. . . don't have quite enough time to do the diagnostic teaching and testing approaches that you'd like to . It was mentioned that we would be better equipped to make institutional referrals, to refer to other agencies with the child here with a little longer concentrated time to deal with each problem. They wanted continuity of contact, long term . . .

(tape change)

. . . There's a special request that next year's reading specialist have the same capabilities as Janet! And this team too asks for a quota. They felt they could consider preparing cases for us if we gave them time like November 15th –

S Oh really.

S (P) February the this, and April the that.

R One of the things that has come out of all the meetings I have had with field people is that there never has been a time when people who have been overtly turned down at one time or another.

S (P) One other – I asked, I had to put point blank to them, would you prefer to have another sector team or do you think the clinic has a role to play? And one person said unless there is this programming facet and in-depth followup then might as well have just the sector team. But you know, not all the team were in agreement with that, they do say that there is a need for such places but & as you know, they haven't shown that they appreciate it.

D You drew a lot more out of them than I did. As I told you before, I did not get any negatives. It seemed to be mostly . . . quite a lot of trouble . . . and we've got enough to do now, enough pressures, without . . . seeing a net benefit to them . . .

S (P) And they certainly won't . . .

D Another thing is that they've had severe limitations in continuity . . .

S . . .

D Any other sector team . . . bring up . . .

S (P) Maybe . . . do you want to present anything on the sector team liaison? There's the question of –

R The only thing that came up in terms of my talking to twelve of the sector people and I've mentioned this to everybody over here and I'm hoping that I can give some honest feedback is that there hve been about five or six of those people and I'm speaking generally, who were wanting to be involved in the final case conferences. I think that one of the things that has happened is that some of the field specialists always feel that they'd like to be on top of it first and they don't like their teachers to know something before they do because they'd like to appear to be knowledgeable and I guess that's pretty important to some of them and also to some of them they love the idea that some of the teachers come in and I think a couple of the teachers have missed their times . . . that was mentioned, but they love coming in. It seems to make the teachers to feel important to come over here and informed. They really

S (SW) That's part of the whole assessment.

R And I think that, I'm hoping that you will keep having these people come in because I think that's really a key thing for PR from this end of it.

S (P) . . . any of my cases where the child has been a behavior problem I've certainly asked but if it's just been a pure academic problem I haven't. Are you saying that you think the benefits would be such because we do have to take it out of our testing time to see them, that we should consider like even if it's not a management problem?

R Well maybe you should clarify that to the sector teams. Because I think that the sector teams have the expectation that the teachers still come in. And so it may just be a matter of little notice at the beginning of the year these are our new changes and list them all really, really carefully at the beginning of the year . . . so many children, only children's teacher will be invited who are behavior problems, if that's what you decide. Just so that the team people are aware. I think the team people like to tell the teachers things and it helps them in their professional approach to people. But if they tell the school the teacher's comming in and then the teacher doesn't come in, that has created a bit of a problem.

D . . . if we could pursue some of the points that you were raising earlier . . . ideally have some consultation with the teams as well . . . During the summer I could undertake to get the necessary reporting . . . so that in our beginning of term . . . these will be the guidelines for the clinic. And I might get you guys to in fact do that particular speech, but the point is that your rules here must be, I think they must be initiated by you, they must be agreeable to you . . . ideally the sector teams would have had some input to those, I have to agree with them and I would like the brass to be informed about them . . . That way we could start the year with everything known.

R Joe, could I just ask you something . . . maybe phone you and just ask you what's happened with the brass since the

D About?

R Whether they will rubber stamp this?

D Yeah.

R It'd be a two-minute phone call.

APPENDIX F
INTERVIEW GUIDE

APPENDIX F. INTERVIEW GUIDE

Interview Questions

1. What are your reasons for making referrals to the Diagnostic Clinic?
2. What types of referrals are the most appropriate Clinic referrals?
3. What are the positive dimensions of clinical services rendered?
4. What are the negative dimensions or side effects?
5. What are the implications if the Diagnostic Clinic were forced to close due to budget restrictions?
6. If given a special grant for expanding services for the Clinic, what would be your recommendations?
7. What are suggestions for improving service delivery given the present structure of the Diagnostic Clinic?
8. How would you compare your present role with that of a specialist in your discipline at the Clinic?
9. How would you restructure the organization?
   (What are the alternatives to twelve field teams to referring clients to one clinic?)
10. What is your reaction to the nature of Clinic liaison with schools? (What additional perceptions do you have regarding the Diagnostic Clinic?)

APPENDIX G
CODED INTERVIEW TRANSCRIPT

APPENDIX G. CODED INTERVIEW TRANSCRIPT

Activity: Interview
Respondent: Field Specialist
Date: April 21, 1981
Code: 1 (Resource Dependence) Need for the Clinic's Service
2 (Response to Problems) Clinic's Capacity to Handle Service
3 (Awareness) School's Knowledge of Clinic
4 (Consensus) Agreement on Outcomes
5 (Domain Similarity) Clinic's Expertise vs. School's Expertise
6 (Intensity) Nature of Communication
7 (Formalization) Coordination of Service
8 (Complexity) Concerns Regarding Tasks
9 (Centralization) Decision Making
10 (Effectiveness)

R Good afternoon. I understand that you have made several referrals in your experience to the Diagnostic Clinic, and I wondered what some of your reasons for referrals were and what types of cases you felt were most appropriate as Clinic referrals.

S Well that changes over time. The history of the Clinic has changed and their
speciality and the type of cases they work best with changes over time too.
3 Orignally the emphasis was on educational program and working with children
who were having difficulties in progressing in school and that was the original
type of referral and I think that was why the Diagnostic Clinic was originally
started but as staff changes, it's had a different emphasis.// Over the last few
years, my perception of the Diagnostic Clinic has been that its strength has
3 been the behavioral disordered children and working with behavior disordered
children and getting them under control so they can operate in the classroom
and make progress.// Now we've just had a major change in staff in the
Diagnostic Clinic and I'm not sure right now what their strength is or whether
3 they're a group of – an interdisciplinary group that each will cooperate in. But
we've referred in the past on – we've referred cases that we felt that they
were able to work with.//

R So right now you're not quite sure whether or not the Clinic is presently structured to handle the behavior problems. Is this what you're saying?

S I don't know the psychologist. In fact I've only talked to her briefly once and
my field experience this year has been with the speech therapist and the
3 reading specialist. I don't know the type of work that they're capable of doing
but I don't know whether the Clinic still possesses a lot of skills in the area –

R Behavior management.

S Yes.

R So that's an area that you hold in question right now?

S I guess you could say that.

R O.K. You've referred several cases in the course of your carreer and I wonder what some of the positive dimensions of the services rendered by the Diagnostic Clinic may be.

S With our current case load one of the positive, one of the most positive aspects of clinic services is intensive family involvement follow-up and
10 programming that they're able to do, having only a few students and having them over a period of three to six weeks rather than the rather massive case loads that the field workers are required to attempt to service.

R So you're talking about ceilings in terms of number of children being referred to the field teams. What about ceiling to the Clinic? Do you have a reaction to that?

S 2 If the Clinic is going to maintain the the intensive reports that they do they would have a ceiling because it's just a matter of time.// One worker can only
8 spend so much time with an individual and if you present too many people to that individual to work with then they are not able to do an intensive job.

R Have you noticed any negative side effects in terms of your referrals which have gone through the Clinic?

S Negative to the student or the parent – ?

R In any of those respects.

S 10 I've never really had any negative side effects from any children that I've referred to the Clinic.// Possibly the only negative thing that I could think of at
7 this point is that the Clinic receiving direct referrals from the schools rather than requiring them to be screened through the field team.

R What can happen in that type of situation if it is not filtered through the field team?

S Well the cases I know of sometimes parents' permission has not been
7 obtained and it can become a messy issue of the Clinic contacts the family that's the first knowledge they have that either their child is having difficulty or their child has been selected and approved for special help.

R So you're suggesting that all of the referrals from the schools be screened by the field teams before they are sent to the Clinic. If they had any recommendations I would like to know what they would be regarding the issue of forced closure of the Clinic due to budget constrictions.

S 1 Well I wouldn't like to see the Diagnostic Clinic closed.// I think that they, by their staff ratio and the number of students they take, they are able to provide a service that very few field teams can provide except on an
5 extremely limited basis and none of the field teams have the observation classroom or the funds to bring students in and work with them over the longer periods that the Clinic is able to do. So I would be opposed to that.

R O.K. What would be the implications for the school system if indeed that happened.

S 1 The implications for the school system would be a reduction in services available for children having a variety of difficulties.

R O.K. If there, this is hypothetically speaking, if there were a special grant for expanding the service for the Clinic, what would you recommend?

S Are you asking what kind of services that the Clinic –

R What would you recommend as an expansion of their overall operation if this money was available?

S 2 Most obvious one would be to decentralize the service so that children are
not required to travel such a long distance.// Since the Clinic is located on the
3 south side students coming from the north side have an extremely long bus
trip to get there.

R So what would you suggest if the service were to be expanded, how would you in fact implement that recommendation. Could you be more specific?

S 2 Create another center that was in a different location so that students would
have to travel less.// I think I would also like to see the Clinic organized along
two different specialties perhaps and it's often hard to differentiate which
2 comes first. I'd like to see one that specializes in behavior disorders and one
that specializes in academic disorders although both go hand in hand // so it
would be very difficult in some cases to decide whether the major or the
8 the prime problem was the behavior disorder or the academic problem but
we do need both kinds of services.

R As the Clinic is currently structured, what suggestions do you have for improving the delivery of services?

S I really don't have any suggestions for changing the current delivery of
services. I think they're operating on quite a good model, it seems to be
10 responsive to the needs of the schools, it seems to be responsive to the
needs of the field teams and // I've been contacted for follow-upand in fact
invited and asked what kind of involvement I would like to have in the case
7 and so I, in consultation with the Clinic, depending on my case load, have been
able to choose what kind of involvement with cases that go to the Clinic that I
have and because of case load pressures // I have usually been involved in
either the school conference when the Clinic report is finalized and coming
7 out or if I was unable to be there, they have sent me the report and reported
that they would be available for discussion and questions.

R What is your reaction to the types of reports which you get? Do you think they are of use in general to the system?

S 10 The reports that I've received in the past have been generally good.

10 the reports have, that I've seen, the major problem was an academic problem
and the case coordinator seemed to have done an excellent job in preparing
and presenting the report.

R How would you compare your present role with that of a specialist in your own discipline in the Clinic?

S In many ways the specialist at the Diagnostic Clinic had similar training and
5 similar experience to me. The main difference is my responsibility is directly
to the schools and I receive my referrals from schools and principals and
counselors and parents.// The degree of the difficulty (of cases) should be
8 higher at the Clinic because of the observation classroom and the longer time
that they have to do intensive work // whereas the volume of referrals that I
receive precludes the possibility of doing that type of intensive work so I
5 would be dealing – I deal with more parents and more students and more
teachers and therefore can't do the intensive job that they're able to do.//

R In terms of the intensity of your job, you've already talked about a ceiling which may help that problem, but if there was an opportunity to restructure the overall organization, including the sector teams and the Diagnostic Clinic, what would your recommendations or alternatives be to a new organizational structure?

S I think the field team has to be, their assignments have to be flexible enough
3 to change with shifting population on a fairly regular basis.// I see the
10 Diagnostic Clinic as a useful organization serving a useful function// and any
reorganization should be done on the basis of the skills and particular abilities
of the staff that is assigned to that clinic. I think if you have people that
specialize in behavior modification then that should be the emphasis of the
Clinic rather than expecting the Clinic to set fixed roles. It should be geared
8 to the abilities of the people who are assigned there// So I'm not indicating
major changes in the overall organization. Probably the most effective change
would be to reduce case loads as I said before, either by increasing staff it
2 that were financially possible, that would be the best approach and if that's
not too likely so I think we're going to have to try to limit our case load to
provide quality service rather than quantity service.

R O.K. We've talked a bit about liaison but what is your reaction to the nature of the Clinic liaison with the schools? Is there any improvement in service delivery that you see needed in that regard?

S In my experience the liaison with the Clinic and schools has been quite good
and they've changed their model somewhat a few years ago to increase that
10 liaison and half their staff is new this year, I really can't give you an accurate
comment but I know in the case where I was included in a school interview
with the Clinic the liaison was excellent.

R O.K. Do you have any additional perspectives regarding the Clinic that you'd like to add?

S The Clinic is the type of organization that requires an intense and an ongoing

4 type of cooperation. In every case it's conferenced several times and the workers work cooperatively and test cooperatively so the success of the Clinic has been largely the degree that people are able to cooperate and work together.// So the Clinic organization in the past dozen years or so that I
4 have been aware of them has been as effective as the people that are there and to the degree that they've been able to cooperate toward a common goal.//

APPENDIX H
ASSESSING LIAISON SYSTEMS BETWEEN SCHOOLS AND ASSESSMENT AGENCIES

APPENDIX H. CRITERIA FOR ASSESSING LIAISON SYSTEMS BETWEEN PSYCHOEDUCATIONAL ASSESSMENT CENTERS AND SCHOOLS

Preconditions for Coordination

There must be a need for outside resources to help resolve problems concerning the pupil.

Psychoeducational assessment agencies must have the capacity to respond to the school's referral within a reasonable amount of time.

School personnel must be aware of the services available from psychoeducational assessment agencies.

There must be agreement between the school personnel and assessment agency concerning the goals for initiating a referral as these goals are related to the outcomes of the service delivered.

Schools should make attempts to exhaust all available alternatives within their sysem before turning to outside agencies for assistance.

Assessing the Coordination System

Time must be made available on the part of the school staff and clinical specialists to allow for adequate communication through phone calls written memos or personal consultation.

Formal mechanisms must be established to ensure that goals are carried out. Flexibility in handling intake for referrals, case conferences, written reports and follow-up is required to cater to the needs of particular schools and parents.

Efforts must be made to integrate the work of teachers and specialists who often view the pupil's problem from different perspectives. Consultation must therefore occur before written reports and case conferences are completed.

School personnel specialists and parents must engage in participative decision-making to ensure that recommendations are practical.

Effectiveness

There must be adequate follow-up by clinical specialists to monitor recommendations and outcomes.